MONTANA LEGISLATIVE HISTORY

Chapter 457 1987

Bill H _____ S 353 Original bill & history ✓ C

H. Committee on Business & Labor		S. Committee on Public Health, Welfare	
Hearing Date(s) 3-20	____C	Hearing Date(s) 2-18	____C
3-24	____C	2-20 12:40pm	C
_____	____C	2-20 7:40pm	C
_____	____C	_____	____C
Date Out _____	____C		

Did this bill originate in an interim committee? ____Yes ____No

Committee _____ Report _____

2/16	INTRODUCED		
2/16	REFERRED TO FISH & GAME		
2/16	FISCAL NOTE REQUESTED		
2/19	FISCAL NOTE RECEIVED		
2/19	HEARING		
2/19	COMMITTEE REPORT--BILL PASSED		
2/21	2ND READING PASSED	49	0
2/23	3RD READING PASSED	49	0
	TRANSMITTED TO HOUSE		
2/24	REFERRED TO FISH & GAME		
3/10	HEARING		
3/12	TABLED IN COMMITTEE		

SB 353 INTRODUCED BY MEYER, LORY, BENGTSON, ET AL.
REGULATE HEALTH MAINTENANCE ORGANIZATIONS
BY REQUEST OF STATE AUDITOR

2/16	INTRODUCED		
2/16	REFERRED TO PUBLIC HEALTH, WELFARE & SAFETY		
2/17	FISCAL NOTE REQUESTED		
2/18	HEARING		
2/21	STATEMENT OF INTENT ADOPTED		
2/21	COMMITTEE REPORT--BILL PASSED AS AMENDED		
2/24	FISCAL NOTE RECEIVED		
2/24	2ND READING PASSED	50	0
2/25	3RD READING PASSED	50	0
	TRANSMITTED TO HOUSE		
3/03	REFERRED TO HUMAN SERVICES & AGING		
3/13	REREFERRED TO BUSINESS & LABOR		
3/20	HEARING		
3/27	COMMITTEE REPORT--BILL CONCURRED AS AMENDED		
3/28	2ND READING CONCURRED	73	0
3/30	3RD READING CONCURRED	97	1
	RETURNED TO SENATE WITH AMENDMENTS		
4/02	2ND READING AMENDMENTS CONCURRED	49	0
4/03	3RD READING AMENDMENTS CONCURRED	49	0
4/07	SIGNED BY PRESIDENT		
4/08	SIGNED BY SPEAKER		
4/08	TRANSMITTED TO GOVERNOR		
4/09	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 457		
	SECTIONS 20, 35 -- EFFECTIVE DATE: 4/09/87		
	SECTIONS 1-19, 21-34 -- EFFECTIVE DATE: 10/01/87		

SB 354 INTRODUCED BY STIMATZ
ABOLISH BOARD OF REGENTS AND REPLACE WITH ELECTED COMMISSIONER

2/17	INTRODUCED		
2/17	REFERRED TO STATE ADMINISTRATION		
2/19	HEARING		
2/19	COMMITTEE REPORT--BILL PASSED		
2/21	2ND READING PASS MOTION FAILED	23	24
	(PROPOSED CONSTITUTIONAL AMENDMENT; PROCEDEED TO 3RD READING)		
2/23	3RD READING FAILED	21	29
	(PROPOSED CONSTITUTIONAL AMENDMENT; PROCEEDED TO OTHER HOUSE)		

SENATE BILL NO. 353

INTRODUCED BY MEYER, LORY, BENGTSON, MILLER, MCLANE, SANDS

BY REQUEST OF THE STATE AUDITOR

IN THE SENATE

FEBRUARY 16, 1987	INTRODUCED AND REFERRED TO COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY.
FEBRUARY 21, 1987	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
	STATEMENT OF INTENT ADOPTED.
FEBRUARY 24, 1987	PRINTING REPORT.
	SECOND READING, DO PASS.
FEBRUARY 25, 1987	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 50; NOES, 0.
	TRANSMITTED TO HOUSE.

IN THE HOUSE

MARCH 3, 1987	INTRODUCED AND REFERRED TO COMMITTEE ON HUMAN SERVICES & AGING.
MARCH 13, 1987	ON MOTION, REREFERRED TO COMMITTEE ON BUSINESS & LABOR.
MARCH 27, 1987	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
MARCH 28, 1987	SECOND READING, CONCURRED IN.
MARCH 30, 1987	THIRD READING, CONCURRED IN. AYES, 97; NOES, 1.
	RETURNED TO SENATE WITH AMENDMENTS.

IN THE SENATE

APRIL 2, 1987	RECEIVED FROM HOUSE.
	SECOND READING, AMENDMENTS CONCURRED IN.
APRIL 3, 1987	THIRD READING, AMENDMENTS CONCURRED IN.
	SENT TO ENROLLING.

Senate BILL NO. 353

INTRODUCED BY Meyer Lory Bengtson Mello

BY REQUEST OF THE STATE AUDITOR McLean Sands

A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE FORMATION AND OPERATION OF HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS 17-7-502 AND 33-22-111, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND AN APPLICABILITY PROVISION."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Short title. This act may be cited as the "Montana Health Maintenance Organization Act".

NEW SECTION. Section 2. Definitions. As used in [sections 1 through 29], unless the context requires otherwise, the following definitions apply:

(1) "Agent" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(2) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

(e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to [section 8(3)(e)];

(f) diagnostic laboratory and diagnostic and therapeutic radiologic services; and

(g) preventive health services, including:

(i) immunizations;

(ii) well-child care from birth;

(iii) periodic health evaluations for adults;

(iv) voluntary family planning services;

(v) infertility services; and

(vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction.

(3) "Commissioner" means the commissioner of insurance of the state of Montana.

(4) "Department of health" means the department of health and environmental sciences provided for in 2-15-2101.

(5) "Director" means the director of the department of health and environmental sciences provided for in 2-15-2102.

(6) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance

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organization contracts to receive health care services.

(7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(8) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

(9) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(10) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers.

(11) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(12) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of his practice or other person who is licensed or otherwise authorized in this state to furnish health care services.

(13) "Uncovered expenditures" mean the costs of health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent.

NEW SECTION. Section 3. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the

commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with [sections 1 through 29]. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first obtains from the secretary of state a certificate of authority to transact business in this state as a foreign corporation under 35-1-1001.

(2) Each health maintenance organization operating in this state as of [the effective date of this act] shall submit an application for a certificate of authority under subsection (3) within 30 days of [the effective date of this act]. Each such applicant may continue to operate in this state until the commissioner acts upon the application. If an application is denied under [section 4], the applicant must be treated as a health maintenance organization whose certificate of authority has been revoked.

(3) Each application of a health maintenance organization, whether separately licensed or not, for a certificate of authority must:

(a) be verified by an officer or authorized representative of the applicant;

(b) be in a form prescribed by the commissioner;

(c) contain:

(i) the applicant's name;

(ii) the location of the applicant's home office or principal office in the United States (if a foreign person);

(iii) the date of organization or incorporation;

(iv) the form of organization (including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors);

(v) the state or country of domicile; and

(vi) any additional information the commissioner may reasonably require; and

(d) set forth the following information or be accompanied by the following documents, as applicable:

(i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto, certified by the public officer with whom the originals were filed in the state or country of domicile;

(ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the applicant's internal affairs, certified by its secretary or other officer having custody thereof;

(iii) a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation; and the partners or members in the case of a partnership or association;

(iv) a copy of any contract made or to be made between:

(A) any provider and the applicant; or

(B) any person listed in subsection (3)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

(v) the extent to which any of the following will be included in provider contracts and the form of any provisions that:

(A) limit a provider's ability to seek reimbursement for basic health care services or health care services from an enrollee;

(B) permit or require a provider to assume a financial risk in the health maintenance organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

(C) govern amending or terminating an agreement with a

provider;

(vi) a financial statement showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of [sections 1 through 29].

(vii) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other source of funding;

(viii) a summary of feasibility studies or marketing surveys that support the financial and enrollment projections for the plan, including the potential number of enrollees in the operating territory, the projected number of enrollees for the first 5 years, the underwriting standards to be applied, and the method of marketing the organization;

(ix) a power of attorney executed by the applicant, on a form prescribed by the commissioner, appointing the commissioner, his successors in office, and his authorized

deputies as the applicant's attorney to receive service of legal process issued against it in this state;

(x) a statement reasonably describing the geographic service area or areas to be served by county, including:

(A) a chart showing the number of primary and specialty care providers with locations and service areas by county;

(B) the method of handling emergency care, with the location of each emergency care facility; and

(C) the method of handling out-of-area services;

(xi) a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

(xii) a description of the complaint procedures to be used as required under [section 11];

(xiii) a description of the procedures and programs to be implemented to meet the quality of health care requirements in [section 4];

(xiv) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under [section 6];

(xv) a summary of the way in which administrative services will be provided, including the size and

qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed for approval with the commissioner in accordance with the filing provisions of [section 8(7)]. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

(C) the method of payment, including any provisions for the administrator to participate in the profits or losses of the plan;

(D) the duration of the contract; and

(E) any provisions for modifying, terminating, or renewing the contract.

(xvi) a summary of current and projected enrollment, income from premiums by type of payer, other income, administrative and other costs, the projected break-even point (including the method of funding the accumulated losses until the break-even point is reached), and the assumptions made in developing projected operating results;

(xvii) a summary of all financial guaranties by

providers, sponsors, affiliates, or parents within a holding company system or any other guaranties that are intended to ensure the financial success of the plan, including hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

(xviii) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

(xix) evidence that it can meet the requirement of [section 13(10)]; and

(xx) any other information that the commissioner may reasonably require to make the determinations required in [section 4].

(4) Each health maintenance organization shall file each substantial change, alteration, or amendment to the information submitted under subsection (3) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may make reasonable rules exempting from the filing requirements of

this subsection those items he considers unnecessary.

(5) An applicant or a health maintenance organization holding a certificate of authority shall file with the commissioner all contracts of reinsurance and any modifications thereto. An agreement between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A reinsurance agreement must remain in full force and effect for at least 90 days following written notice of cancellation by either party by certified mail to the commissioner.

(6) Each health maintenance organization shall maintain, at its administrative office, and make available to the commissioner upon request executed copies of all provider contracts.

NEW SECTION. Section 4. Issuance of certificate of authority. (1) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall transmit copies of the application and accompanying documents to the department of health. The department of health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished, has:

(a) demonstrated the willingness and potential ability to assure that it will provide health care services in a manner assuring availability and accessibility of adequate

personnel and facilities and enhancing availability, accessibility, and continuity of service;

(b) arrangements, established in accordance with the rules made by the department of health, for an ongoing quality assurance program concerning health care processes and outcomes; and

(c) a procedure, established in accordance with rules of the department of health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and any other matters as may be reasonably required by the department of health.

(2) Within 90 days of receipt of the application from a health maintenance organization for issuance of a certificate of authority, the department of health shall certify to the commissioner that the proposed health maintenance organization meets the requirements of subsection (1) or shall notify the commissioner that the health maintenance organization does not meet those requirements and specify in what respects it is deficient. The director may extend by not more than an additional 30 days the period within which he may certify to the commissioner that the proposed health maintenance organization meets or does not meet the requirements of

subsection (1) by giving notice of the extension to the commissioner and the health maintenance organization before the expiration of the initial 90-day period.

(3) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to [section 3] within 180 days of receipt of the certification from the department of health. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in [section 22] if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent, trustworthy, and of good reputation.

(b) The department of health certifies, in accordance with subsection (2), that the health maintenance organization's proposed plan of operation meets the requirements of subsection (1).

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

(d) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In

making this determination, the commissioner may in his discretion consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with [section 13]; and

(vi) any additional information as the commissioner may reasonably require.

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to [section 6].

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to [section 3] or by independent investigation, is contrary to the public interest.

(g) Any deficiencies identified by the department of health have been corrected.

(4) The commissioner may in his discretion deny a certificate of authority only if he complies with the requirements of [section 21].

NEW SECTION. Section 5. Powers of health maintenance organizations. (1) The powers of a health maintenance organization include but are not limited to the following:

(a) the purchase, lease, construction, renovation, operation, or maintenance of a hospital, a medical facility, or both, its ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(b) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation under its control for the purpose of acquiring or constructing a medical facility or hospital or in furtherance of a program providing health care services to enrollees;

(c) the furnishing of health care services through a provider who is under contract with or employed by the health maintenance organization;

(d) the contracting with a person for the performance on its behalf of certain functions, such as marketing,

enrollment, and administration;

(e) the contracting with an insurer authorized to transact insurance in this state, or with a health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization; and

(f) the offering of other health care services in addition to basic health care services.

(2) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner before exercising a power granted in subsection (1)(a), (1)(b), or (1)(d). The commissioner may disapprove the exercise of a power only if, in his opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. The commissioner may make reasonable rules exempting from the filing requirement of this subsection those activities having a de minimis effect. The exercise of authority granted in subsections (1)(a), (1)(b), and (1)(d) is subject to disapproval by the commissioner. The commissioner may exempt certain contracts from the filing requirement whenever exercise of the authority granted in this section would have little or no effect on the health maintenance organization's financial

condition and ability to meet obligations.

(3) Nothing in this section exempts the activities of a health maintenance organization from any applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 6. Governing body. (1) The governing body of a health maintenance organization may include providers or other individuals, or both.

(2) The governing body shall establish a mechanism to give the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

NEW SECTION. Section 7. Fiduciary responsibilities. (1) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in the manner of a fiduciary to the health maintenance organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner. Each bond must be written with at least a 1-year discovery period and, if written with

less than a 3-year discovery period, must contain a provision that a cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, may not take effect prior to the expiration of 90 days after written notice of the cancellation or termination has been filed with the commissioner unless the commissioner approves an earlier cancellation or termination date.

NEW SECTION. Section 8. Evidence of coverage and charges for health care services. (1) Every enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is unjust, unfair, inequitable, misleading, or deceptive; that encourages misrepresentation; or that is untrue, misleading, or deceptive as defined in [section 14(1)]. The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of

similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment, which is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health

care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or his dependents;

(f) a provision offering medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits provided in 33-22-703;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, his dependents, or family members continuing coverage on the enrollee, his dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, his dependents, or family members covered

under the evidence of coverage ceases because of termination of employment or of his membership in the class or classes eligible for coverage under the policy or because his employer discontinues his business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for

newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or his dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees,

except that charges applicable to an enrollee must not be individually determined based on the status of his health. However, the charges may not be excessive, inadequate, or unfairly discriminatory and cannot be amended more often than once in a 12-month period unless a more frequent amendment is actuarially justified and necessary to preserve the financial solvency of the health maintenance organization. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the charges, based on reasonable assumptions, must accompany the filing, along with adequate supporting information.

(7) The commissioner shall, within a reasonable period, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form or use a schedule of charges before the commissioner approves the form or the health maintenance organization files the schedule of charges. If the commissioner disapproves the filing, he shall notify the filer. In the notice, the commissioner shall specify the reasons for his disapproval. The commissioner shall grant a hearing within 30 days after he receives a written request by the filer.

(8) The commissioner may in his discretion require a health maintenance organization to submit any information he

considers necessary in determining whether to approve or disapprove a filing made pursuant to this section.

NEW SECTION. Section 9. Annual statement -- revocation for failure to file -- penalty for perjury. (1) Each authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may in his discretion waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in [section 22]. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in [section 22], or may in his discretion suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may impose a fine not to exceed $5,000 per violation upon a director, officer, partner, member, agent, or employee of a health maintenance

organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement which is false.

(4) The commissioner may require such reports as he considers reasonably necessary and appropriate to enable him to carry out his duties under [sections 1 through 29].

NEW SECTION. Section 10. Information to enrollees. Each authorized health maintenance organization shall promptly provide to its enrollees notice of any material change in the operation of the health maintenance organization that will affect them directly.

NEW SECTION. Section 11. Complaint system. (1) (a) Each authorized health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures to resolve written complaints initiated by enrollees. A health maintenance organization may not use a complaint system:

(i) before the commissioner approves it; and

(ii) unless the health maintenance organization describes it in each evidence of coverage issued or delivered to an enrollee in this state.

(b) Each time the health maintenance organization denies a claim or initiates disenrollment, cancellation, or nonrenewal, it shall notify the affected enrollee of the right to file a complaint and the procedure for filing a

complaint.

(c) Each health maintenance organization shall acknowledge a complaint within 10 days of receiving it.

(d) Each health maintenance organization shall retain records of all complaints for 3 years and shall develop a summary for each year that must include:

(i) a description of the procedures of the complaint system;

(ii) the total number of complaints handled through the complaint system, a compilation of causes underlying the complaints filed, the date on which each complaint was filed, the date on which each complaint was resolved, the disposition of each complaint filed, the time it took to process each complaint, and a summary of each administrative change made because of a complaint; and

(iii) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that were settled during the year by the health maintenance organization.

(e) The health maintenance organization shall annually on or before March 1 file with the commissioner the summary described in subsection (1)(d) for the preceding year.

(2) The commissioner shall hold in confidence the information provided by the health maintenance organization pursuant to subsection (1)(d)(iii).

(3) The commissioner may examine a complaint system.

NEW SECTION. Section 12. Investment regulations. A domestic health maintenance organization may invest its funds only as prescribed in rules adopted by the commissioner.

NEW SECTION. Section 13. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation must be the greater of:

(a) 5% of its estimated expenditures for health care services for its first year of operation;

(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or

(c) $100,000.

(3) At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on [the effective date of this act] shall make a deposit equal to the greater of:

(a) 1% of the preceding 12 months' uncovered expenditures; or

(b) $100,000 on the first day of the fiscal year beginning 6 months or more after [the effective date of this act]. In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably reflect the preceding year's operating experience and delivery arrangements.

(5) The commissioner may in his discretion waive any of the deposit requirements set forth in subsections (1) through (4) whenever he is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year;

(b) the health maintenance organization's performance

and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth not including land, buildings, and equipment of at least $1 million or achieves a net worth including organization-related land, buildings, and equipment of at least $5 million the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth not including land, buildings, and equipment of at least $1 million or that has been in operation for at least 10 years and has a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement under subsection (3) does not apply. If the

guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of such health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from

the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, except that its total deposit may not be required to exceed the maximum required under this section.

(9) Each health maintenance organization shall have a minimum capital of at least $200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

(a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

(b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical underwriting or preexisting limitation requirements.

NEW SECTION. Section 14. Prohibited practices. (1) A health maintenance organization, or representative thereof, may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of [sections 1 through 29]:

(a) a statement or item of information is considered to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee of, or person considering enrollment in, a health maintenance organization;

(b) a statement or item of information is considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, a reasonable person, not possessing special knowledge regarding health care coverage, may reasonably understand the statement or item of information as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

(c) an evidence of coverage is considered to be deceptive if, when taken as a whole and with consideration given to typography, format, and language, it can cause a reasonable person, not possessing special knowledge regarding health maintenance organizations, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage

does not regularly make available to enrollees covered under the evidence of coverage.

(2) Title 33, chapter 18, applies to health maintenance organizations and evidences of coverage issued by a health maintenance organization, except to the extent that the commissioner determines that the nature of health maintenance organizations and evidences of coverage render the chapter clearly inappropriate.

(3) A health maintenance organization shall clearly disclose in the evidence of coverage the circumstances under which it may disenroll, cancel, or refuse to renew an enrollee. A health maintenance organization may only disenroll, cancel, or refuse to renew an enrollee if the enrollee:

(a) has failed to pay required premiums by the end of the grace period;

(b) has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees of the health maintenance organization;

(c) has allowed a nonenrollee to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;

(d) has moved outside of the geographical service area of the health maintenance organization; or

(e) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that he may file a grievance on this matter.

(4) A health maintenance organization may not disenroll an enrollee under subsection (3) for reasons related to the physical or mental condition of the enrollee or for any of the following reasons:

(a) failure of the enrollee to follow a prescribed course of treatment; or

(b) administrative actions, such as failure to keep an appointment.

(5) (a) A health maintenance organization that disenrolls a group certificate holder for any reason except failure to pay required premiums shall make arrangements to provide similar alternate insurance coverage to enrollees. The insurance coverage must be continued until the disenrolled group certificate holder finds its own coverage or a period of 36 months elapses, whichever comes first. The

premium on the individual coverage must be at the then-customary rate applicable to the individual coverage offered by the insurer, health service corporation, or health maintenance organization that provides the alternate insurance coverage.

(b) If a health maintenance organization disenrolls an enrollee covered on an individual basis for any reason except failure to pay required premiums, coverage must be continued until the anniversary date of the policy or for 1 year, whichever is earlier. A health maintenance organization that disenrolls an individual enrollee for failure to pay a required premium or for fraudulent statements on the enrollment form need not provide alternate insurance coverage to that enrollee.

(6) A health maintenance organization may not refer to itself as an insurer unless licensed as an insurer or use a name deceptively similar to the name or description of an insurer authorized to transact insurance in this state.

(7) A person may not refer to itself as a health maintenance organization or HMO unless it holds a valid certificate of authority issued by the commissioner.

NEW SECTION. Section 15. Agent license required -- application, issuance, renewal, fees -- penalty. (1) No individual, partnership, or corporation may act as or hold himself out to be an agent of a health maintenance

organization unless he is:

(a) licensed as a disability insurance agent by the commissioner pursuant to chapter 17, parts 1, 2, and 4 of this title; and

(b) appointed or authorized by the health maintenance organization to solicit health care service agreements on its behalf.

(2) Application, appointment and qualification for a health maintenance organization agent license, fees applicable to and the issuance of a health maintenance organization agent license, and renewal of a health maintenance organization agent license must be in accordance with the provisions of chapter 17 that apply to a disability insurance agent.

(3) An individual, partnership, or corporation who holds a disability insurance agent license on [the effective date of this act] need not requalify by an examination to be licensed as a health maintenance organization agent.

(4) The commissioner may, in accordance with 33-1-313, 33-1-317, 33-17-411, and chapter 17, part 10, suspend, revoke, refuse to issue or renew a health maintenance organization agent license, or impose a fine upon the licensee.

NEW SECTION. Section 16. Powers of insurers and health service corporations. (1) An insurer authorized to

transact insurance in this state or a health service corporation authorized to do business in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of [sections 1 through 29]. Notwithstanding any other law which may be inconsistent with this section, two or more insurers, health service corporations, or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance is considered to include the provision of health care services by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any insurance or health service corporation laws, an insurer or a health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance organization and to provide coverage if the health maintenance organization fails to meet its obligations.

(3) The enrollees of a health maintenance organization constitute a permissible group under this title. The insurer or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers under the contracts described in subsection (2).

(4) Nothing in this section exempts a health maintenance organization that provides health care services from complying with the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 17. Examination. (1) The commissioner may examine the affairs of a health maintenance organization and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary to protect the interests of the people of this state. The commissioner shall make such an examination at least once every 3 years.

(2) The department of health may examine the quality of the health care services provided by any health maintenance organization and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary to protect the interests of the people of this state. The department of health shall make such an examination at least once every 3 years.

(3) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner and the department of health may administer oaths to and examine the officers and agents of the health

maintenance organization and the principals of the providers concerning their business.

(4) (a) (i) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or adopted by the commissioner. The commissioner may present such an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any such examination.

(ii) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (4)(a)(i), the commissioner shall pay them out of the funds of the commissioner in the same manner as other disbursements of such funds. The amount so paid must be a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund.

(b) The expenses of examination conducted by the

director under this section must be assessed against the health maintenance organization and remitted to the director. Such remitted expenses are statutorily appropriated to the department of health as provided in 17-7-502.

(5) In lieu of an examination, the commissioner or the director may accept the report of an examination made by the commissioner or the director of another state.

NEW SECTION. Section 18. Suspension or revocation of certificate of authority. (1) The commissioner may in his discretion suspend or revoke any certificate of authority issued to a health maintenance organization under [sections 1 through 29] if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under [section 3], unless amendments to such submissions have been filed with and approved by the commissioner.

(b) The health maintenance organization issues evidences of coverage or uses a schedule of charges for health care services that do not comply with the requirements of [section 8].

(c) The health maintenance organization does not

provide or arrange for basic health care services.

(d) The director certifies to the commissioner that:

(i) the health maintenance organization does not meet the requirements of [section 4(1)]; or

(ii) the health maintenance organization is unable to fulfill its obligations to furnish health care services.

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under [section 6].

(g) The health maintenance organization has failed to implement the complaint system required by [section 11] to resolve valid complaints in a reasonable manner.

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(j) The health maintenance organization has otherwise failed to substantially comply with [sections 1 through 29].

(2) The commissioner may in his discretion suspend or revoke a certificate of authority only if he complies with the requirements of [section 21].

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of such suspension, enroll any additional enrollees except newborn infants or other newly acquired dependents of existing enrollees and may not engage in any advertising or solicitation.

(4) If the commissioner revokes the certificate of authority of a health maintenance organization, the health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may not transact further business except as may be essential to the orderly conclusion of its affairs. It may not engage in further advertising or solicitation following the effective date of the order of revocation. The commissioner may by written order permit further operation of the health maintenance organization it he finds further operation to be in the best interest of enrollees to the extent that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

NEW SECTION. Section 19. Supervision, rehabilitation,

or liquidation of a health maintenance organization. (1) The supervision, rehabilitation, or liquidation of a health maintenance organization is considered to be the supervision, rehabilitation, or liquidation of an insurer and must be conducted under the supervision of the commissioner pursuant to chapter 2, part 13. The commissioner may apply for an order directing him to supervise, rehabilitate, or liquidate a health maintenance organization upon any one or more grounds set out in 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as a claim by an enrollee if the provider of services agrees not to assert the claim against any enrollee of the health maintenance organization.

NEW SECTION. Section 20. Rules. (1) The commissioner may, after notice and hearing, make reasonable rules necessary to effectuate [sections 1 through 29].

(2) The department of health may make reasonable rules necessary to effectuate [sections 1 through 29].

NEW SECTION. Section 21. Administrative procedures.

(1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist or that grounds for the suspension or revocation of a certificate of authority exist, he shall give written notice to the health maintenance organization and the department of health specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days after the notice for a hearing on the matter.

(2) The director or his designated representative may attend the hearing and may participate in the proceeding. The recommendations and findings of the director with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority must be conclusive and binding upon the commissioner. After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall make written findings and act as he considers advisable. The commissioner shall mail the written findings to the health maintenance organization and submit a copy to the director. The action of the commissioner and the recommendations and findings of the director are subject to review by the district court having jurisdiction. The court may, in disposing of the issue

before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

(3) The Montana Administrative Procedure Act, Title 2, chapter 4, applies to proceedings under this section to the extent it is not in conflict with this section.

NEW SECTION. Section 22. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

(a) for filing an application for a certificate of authority or amendment thereto, $300;

(b) for filing an amendment to the organization documents that requires approval, $25;

(c) for filing each annual statement, $25.

(2) All fees and miscellaneous charges, except fines or penalties or those amounts received pursuant to [sections 9(3) and 23], collected by the commissioner pursuant to [sections 1 through 29] and the rules adopted thereunder must be deposited in the insurance regulatory trust account pursuant to 17-2-121 through 17-2-123.

(3) The director may assess fees necessary and adequate to cover the expenses of the director's functions, other than examinations, under this chapter. Such fees are statutorily appropriated to the department of health as provided in 17-7-502.

NEW SECTION. Section 23. Penalties and enforcement.

(1) The commissioner may, in addition to suspension or revocation of a certificate of authority under [section 18], impose an administrative penalty in an amount not less than $500 or more than $10,000 if he gives reasonable notice in writing of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

(2) (a) If the commissioner or the director has cause to believe that a violation of [sections 1 through 29] has occurred or is threatened, the commissioner or the director may:

(i) give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation;

(ii) arrange a conference with the alleged violators or their authorized representatives to attempt to ascertain the facts relating to the suspected violation; and

(iii) if it appears that a violation has occurred or is threatened, arrive at an adequate and effective means of correcting or preventing the violation.

(b) Proceedings under this subsection are not governed

by any formal procedural requirements and may be conducted in a manner the commissioner or the director considers appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of [section 21] or this section are satisfied.

(3) (a) The commissioner may issue an order directing a health maintenance organization or its representative to cease and desist from engaging in an act or practice in violation of [sections 1 through 29].

(b) Within 15 days after service of the cease and desist order, the respondent may request a hearing to determine whether acts or practices in violation of [sections 1 through 29] have occurred. The hearing must be conducted pursuant to Title 2, chapter 4, part 6, and judicial review must be available as provided by Title 2, chapter 4, part 7.

(4) If a health maintenance organization violates a provision of [sections 1 through 29] and the commissioner elects not to issue a cease and desist order or if the respondent does not comply with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lewis and Clark County.

NEW SECTION. Section 24. Statutory construction and relationship to other laws. (1) Except as otherwise provided in [sections 1 through 29], the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under [sections 1 through 29]. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to [sections 1 through 29].

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under [sections 1 through 29] may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of [sections 1 through 29] do not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 25. Filings and reports as

public documents. All applications, filings, and reports required under [sections 1 through 29], except those that contain trade secrets or privileged or confidential commercial or financial information (other than an annual financial statement that the commissioner may require under [section 9]), are public documents.

NEW SECTION. Section 26. Confidentiality of medical information. (1) Any data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant obtained from the enrollee, applicant, or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except:

(a) to the extent that it may be necessary to carry out the purposes of [sections 1 through 29];

(b) upon the express consent of the enrollee or applicant;

(c) pursuant to statute or court order for the production of evidence or the discovery thereof; or

(d) in the event of claim or litigation between the enrollee or applicant and the health maintenance organization wherein the data or information is pertinent.

(2) A health maintenance organization is entitled to claim the same statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

NEW SECTION. Section 27. Authority of director to contract. The director in carrying out his obligations under [sections 4(1), 17(2), and 18(1)] may contract with qualified persons to make recommendations concerning the determinations he is required to make. The contractors' recommendations may be accepted in full or in part by the director.

NEW SECTION. Section 28. Acquisition, control, or merger of a health maintenance organization. (1) Except as provided in 33-2-1106 and subsection (2), no person may tender for, request, or invite tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization.

(2) No person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the acquiring person has filed with the commissioner and has sent to the health

maintenance organization information required by 33-2-1104(2) and the commissioner has approved the offer, request, invitation, agreement, or acquisition pursuant to 33-2-1105.

NEW SECTION. Section 29. Dual choice. (1) Each public or private employer in this state that employs not less than 25 employees and offers its employees a health benefit plan and each employee benefit fund in this state that offers its members any form of disability insurance benefit shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority that provides health care services in the geographic areas in which a substantial number of the employees or members reside. If there is a prevailing collective bargaining agreement, the selection of the health maintenance organization to be made available to the employees must be made pursuant to the agreement.

(2) An employer in this state may not be required to pay more for health benefits as a result of the application of this section than it would otherwise be required to provide by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, if the employer or benefits fund pays to the health maintenance organization chosen by each employee or

member an amount equal to the lesser of:

(a) the amount paid on behalf of its other employees or members of health benefits; or

(b) the health maintenance organization's charge for coverage approved by the commissioner pursuant to [section 8].

Section 30. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) ~~All~~ Except as provided in [sections 1 through 29], all policies of disability insurance, including individual, group, and blanket policies, and all policies insuring the payment of compensation under the Workers' Compensation Act shall provide the insured shall have full freedom of choice in the selection of any duly licensed physician, dentist, osteopath, chiropractor, optometrist, chiropodist, psychologist, licensed social worker, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of his practice. Whenever such policies insure against the expense of drugs, the insured shall have full freedom of choice in the selection of any duly licensed and registered pharmacist. An insurer shall offer, at additional cost to the insured, the option of disability and health insurance coverage for

services performed by a licensed professional counselor.

(2) Nothing in this section shall be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1); nor shall this section be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

Section 31. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;

(b) 2-17-105;

(c) 2-18-812;

(d) 10-3-203;

(e) 10-3-312;

(f) 10-3-314;

(g) 10-4-301;

(h) 13-37-304;

(i) 15-31-702;

(j) 15-36-112;

(k) 15-70-101;

(l) 16-1-404;

(m) 16-1-410;

(n) 16-1-411;

(o) 17-3-212;

(p) 17-5-404;

(q) 17-5-424;

(r) 17-5-804;

(s) 19-8-504;

(t) 19-9-702;

(u) 19-9-1007;

(v) 19-10-205;

(w) 19-10-305;

(x) 19-10-506;

(y) 19-11-512;

(z) 19-11-513;

(aa) 19-11-606;

(bb) 19-12-301;

(cc) 19-13-604;

(dd) 20-6-406;

(ee) 20-8-111;

(ff) 23-5-612;

(gg) [section 17];

(hh) [section 22];

~~(gg)~~(ii) 37-51-501;

~~(hh)~~(jj) 53-24-206;

~~(ii)~~(kk) 75-1-1101;

~~(jj)~~(ll) 75-7-305;

~~(kk)~~(mm) 80-2-103;

~~(ll)~~(nn) 80-2-228;

~~(mm)~~(oo) 90-3-301;

~~(nn)~~(pp) 90-3-302;

~~(oo)~~(qq) 90-15-103; and

~~(pp)~~(rr) Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount

sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments."

NEW SECTION. Section 32. Codification instruction. Sections 1 through 29 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through 29.

NEW SECTION. Section 33. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 34. Effective date -- applicability. This act is effective on passage and approval and applies to health maintenance organizations formed before or after the effective date of this act.

-End-

STATE OF MONTANA - FISCAL NOTE
Form BD-15

In compliance with a written request, there is hereby submitted a Fiscal Note for SB353 , as introduced.

DESCRIPTION OF PROPOSED LEGISLATION:

An act to regulate the formation and operation of Health Maintenance Organizations; amending Sections 17-7-502 and 33-22-111, MCA; and providing an immediate effective date and an applicability provision.

ASSUMPTIONS:

1. There would be four HMO's authorized in FY88 and these companies would renew in FY89.
2. Each HMO will register 10 agents in FY88 and FY89.
3. There will be no additional staff required for the State Auditor.
4. The Department of Health and Environmental Sciences will require 1.0 additional FTE to administer the program.
5. DHES will contract for patient care assessments and complaint reviews at $35.00 per case.
6. An estimated number of 56,000 persons will be enrolled in HMO's, requiring 1,867 case reviews per year. (The enrolled population was estimated from combining the greater Helena, Missoula and Great Falls areas and larger population centers in the northeastern portion of the state. It was then assumed that about one-third of this total would enroll in HMO's.)
7. An estimated 225 complaints will be investigated per year.
8. The State Auditor will do ongoing financial audits of HMO's and DHES will be responsible for ongoing patient care assessments of HMO's.
9. If HMO's expand beyond currently estimated enrollment of 57,000 persons, costs and revenues will increase above those shown in this fiscal note.

FISCAL IMPACT:

	FY88		FY89	
	Current Law	Proposed Law	Current Law	Proposed Law
Expenditures:				
Personal Services	$ 0	$ 28,438	$ 0	$ 28,438
Operating Costs	0	78,887	0	78,887
Capital Outlay	0	3,000	0	0
TOTAL	$ 0	$ 110,325	$ 0	$ 107,325

David L. Hunter DATE 2/23/87
DAVID L. HUNTER, BUDGET DIRECTOR
Office of Budget and Program Planning

D Meyer DATE
DARRYL MEYER, PRIMARY SPONSOR

Fiscal Note for SB353, as introduced.

SB 353

FISCAL IMPACT:

	FY88		FY89	
	Current Law	Proposed Law	Current Law	Proposed Law
Revenues:				
State Special Revenue	$ 0	$ 111,925	$ 0	$ 107,825
Net Impact:	$ 0	$ 1,600	$ 0	$ 500

NOTE: If University System employees are offered an HMO option as part of health care benefits, state costs could increase by about $260,000 each year. The state could expect an increase in costs of 2 - 5 % each year. See long-term effects.

LONG-RANGE EFFECTS OF PROPOSED LEGISLATION:
Most plans (including the state self-insured plan) will be impacted by the introduction of HMO's. Retirees are less likely to join HMO's because of long-term physician relationships and because many live out-of-state at least part of the year. The traditional plans end up with a larger retiree mix. In Kansas, which recently introduced HMO's, 29% of the active employees joined HMO's and only 2% of the retirees joined. Because retirees utilize the plan at a higher rate, a shift of current employees to HMO's results in higher costs to the state plan because fewer active employees would subsidize the retiree costs. With a shift similar to Kansas, the state could expect up to a 5% increase in cost to the state plan, probably resulting in pressure to increase the state share by a similar amount to maintain current benefits.

TECHNICAL OR MECHANICAL DEFECTS IN PROPOSED LEGISLATION OR CONFLICTS WITH EXISTING LEGISLATION:
This bill does not clearly specify the parameters of the patient care assessments to be performed by DHES. If DHES is required to perform a cost analysis as appropriate to the services delivered, personnel and operating costs to administer the proposed law will double.

MONTANA STATE SENATE

PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

50th LEGISLATURE

COMMITTEE MEMBERS:	Senator Dorothy Eck, Chairman Senator Tom Hager, V. Chairman Senator Matt Himsl Senator Judy Jacobson Senator Harry H. McLane Senator Darryl Meyer Senator Bill Norman Senator Tom Rassmussen Senator Eleanor Vaughn Senator Bob Williams
STAFF RESEARCHER:	Karen Renne
COMMITTEE SECRETARY:	Ellen Nehring
BOOK:	1 of 2
INCLUSIVE DATES:	January 7, 1987 through February 20, 1987

CHAIRMAN--SEN. DOROTHY ECK
NORMAL SCHEDULE==> SITE: ROOM 410 DAYS: M-W-F TIME: 1:00 P.M.

SECRETARY-ELLEN NEHRING

BILL NO	REFER DATE	HEARING DATE	CONSIDERATION DATES	COMMITTEE ACTION	REREFERRED TO COMM	DATE OUT
SB0252	1/29				JUDICIARY	
REGAN, PAT			PERMIT DISABILITY INSURANCE POLICIES TO CONTAIN A SUBROGATION CLAUSE			
SB0290	2/05	2/13		ADVERSE REPORT		2/16/87
VAUGHN, ELEANOR			REQUIRE PHARMACIES TO POST PRICE AND GENERIC EQUIVALENT OF BRAND-NAME DRUGS			
SB0305	2/06	2/16		PASS AS AMENDED		2/18/87
ECK, DOROTHY			ALLOW QUALIFIED DENTISTS TO PERFORM PHYSICAL EXAMS ON HOSPITAL ADMISSIONS			
SB0349	2/16	2/18			No Action	
REGAN, PAT			AUTHORIZE AND REGULATE HEALTH MAINTENANCE ORGANIZATIONS			
SB0351	2/17	2/20		PASS AS AMENDED		2/20/87
WALKER, MIKE			ENTERING PACIFIC STATES AGREEMENT ON RADIOACTIVE MATERIALS TRANSPORTATION			
SB0353	2/16	2/18		PASS AS AMENDED		2/20/87
MEYER, DARRYL			REGULATE HEALTH MAINTENANCE ORGANIZATIONS			
SB0371	2/18	2/20		PASS AS AMENDED		2/20/87
REGAN, PAT			REGULATE PREFERRED PROVIDER ARRANGEMENTS			
SJ0001	1/05	1/07		DO PASS		1/14/87
GAGE, DELWYN			OPPOSING INDIAN HEALTH SERVICE REGS LIMITING ELIGIBILITY FOR HEALTH CARE			
SJ0008	1/26	2/11		PASS AS AMENDED		2/13/87
KEATING, THOMAS F.			RESOLUTION TO ENDORSE RECOMMENDATIONS OF DEVELOPMENTAL PLANNING TASK FORCE			
SJ0013	3/10	4/01		DO PASS		4/10/87
KEATING, THOMAS F.			STUDY CONSOLIDATION OF SERVICES FOR DEVELOPMENTALLY DISABLED PERSONS			

MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE
MONTANA STATE SENATE

February 18, 1987

ACTION ON SENATE BILL NO. 246: Senator Jacobson moved that S.B. 246 do pass.
Sen. Williams: Will this bill make us another $200,000 short?
Sen. Himsl: This is not a totally perfect operation, but it doesn't put us in a penalty situation to have it, and it may if we don't. The budget cost is $125,000, and it is worth it if it saves us from some unnecessary projects.
Sen. Williams: Is the CON a cost-sharing expense with the Federal government?
Rose Skoog: There have been federal funds in the past in the program, but not now. The rest will be picked up by application fees.
Sen. Williams: Then the state share will not be picked up by application fees. Can there be a fiscal note before second reading?
Sen. Norman: I will authorize a fiscal note to be ready quickly.
Sen. Jacobson called for the question. S.B. 246 received a DO PASS with Senators Norman, Williams, and McLane voting no.

ACTION ON SENATE BILL NO. 305: Karen Renne explained the amendments to the bill (see attached committee report). Sen. Eck moved that the amendments and the Statement of Intent receive a DO PASS. The vote was a unanimous DO PASS. Sen. Eck moved that S.B. 305 DO PASS AS AMENDED. The bill received a Unanimous DO PASS AS AMENDED.

CONSIDERATION OF SENATE BILLS NOS. 349 AND 353: Sen. Pat Regan, District # 47, introduced S.B. 349 and asked that those testifying present the concept and the specifics of the bill.
Sen. Darryl Meyer, District # 17, introduced S.B. 353, stating that the purpose of the bill is to provide regulations for Health Maintenance Organizations, a new concept in health care, now starting up in Montana. Since the two bills are very similar, the committee elected to hear testimony on both bills together.

PROPONENTS: Kathy Irigoin, lawyer with the State Auditor's office, stated that the Auditor's office prefers their bill, # 353, and her testimony will explain some of the differences between the two bills. The existing Freedom of Choice Practices law prevents most types of HMO's from operating in Montana; only HMOs meeting Federal requirements can operate, since Federal law pre-empts state law. The state auditor's bill meaningfully addresses financial solvency of an HMO and consumer protection, such as the evidence that coverage contain a definition of key terms, a clear disclosure of benefits, and provisions for disenrolling members. The bill also states that consumers cannot pay more for HMO coverage than they would for normal insurance coverage. The State Auditor's bill also requires payment for drug and alcohol and mental health services, which S.B. 349 does not. On P. 22, Line 8, she recommended an amendment making mental health coverage a mandatory benefit, not a mandatory offer.

S.B. 349 does not include the authority to contract and does not

have as much authority to regulate or give rule-making authority to the Department of Health. S.B. 353 also can authorize the assessment of fees to cover expenses, which S.B. 349 does not do. S.B. gives thirty days to issue or deny a certificate of authority, which is too short a time period. S.B. 353 gives 180 days, plus a 30-day extension, which is too long a time period. Exhibit # 2.

Robert Phillips, Montana Medical Association, testified that the association has had substantial input into the drafting of the bills. They feel that if HMO's are coming, they must be regulated; and they now support the inclusion of mandated services for mental health, drug and alcohol abuse under the definition of "Basic Mental Health Care" because it affects all classes, ages and sexes of people. They do not support mandated coverage for maternity and well-child care because these do not affect everyone. They find S.B. 353 more regulatory and closer to the Model Act. S.B. 353 gives the Auditor's office 180 days to act on an HMO application and that, added to the Dept. of Health's 90 days, is too long for a smaller HMO trying to open. The regulatory scheme of S.B. 353 or S.B. 349 should apply to all HMO's, regardless of their sponsor. While HMO's are not the entire answer to health care costs, they are coming; and legislation needs to be enacted to ensure their regulation.

Steve Waldron, Montana Mental Health Centers, stated that he supports the HMO concept, but sees the need for mandated coverage for mental health, drug and alcohol abuse, which S.B. 349 offers, but which S.B. 353 does not.

Dr. Armand Altman, Consultant Psychiatrist from the state of New York, stated that he support S.B. 349 as it relates to mandatory benefits for mental health, drug and alcohol use. The National Association of Mental Health has discovered that in times of crisis, if people don't receive mental health help, they often end up abusing drugs or alcohol. Prevention comes through a mandatory requirement that those services be offered. It is a committment to serving citizens.

Joy McGrath, Mental Health association, supports the HMO concept if it offers total health services for the community. S.B. 349 clearly offers this coverage, and S.B. 353 can, if amended. Ex.# 3.

Bill McDonald, Group Health for WestMont, supports the HMO concept because health care costs are increasing too rapidly and growing numbers of people cannot afford haelth care costs. HMO's provide reasonable comprehensive heatlh coverage to a population.

In an HMO a delivery system is prepaid, people (consumers) are involved in the management of the program, and more reasonable costs will hopefully motivate the public to take more responsibility for health care and planning for an aging population. Neither physisian nor doctors have little financial incentive now to reduce costs. The organization supports S.B. 349 because of the mandated mental health benefits. They feel that the 180-day requirement is

too long; the additional 90 days makes 270 days, and that is too long for the industry. He stated that it is a waste of time for everyone listed in Sec. 53, P.8, to review provisions, and he suggested dropping parts A,B, & C of Sec. 10.

Judith Carlson, National Association of Social Workers, stated the the NASW supports S.B. 349 because of its support of mandated mental health services and because it regulates HMO's according to the existing insurance laws of this state. Exhibit #4.

Mike Murray, Chemical Dependency Program of Montana, supports S.B. 349 because of coverage of mental health services and chemical abuse coverage, or he recommends amending S.B. 353 to include mandated coverage of the mentioned services.

Ann Scott, Rocky Mountain Treatment Center, stated that mandated coverage of mental health and chemical dependency treatment is important. S.B. 353 has good provisions looking the management and stability of HMO's and it provides for coverage under the CON bill, but it is not clear if that covers both buildings and services. Both need to be covered under the CON bill.

Jack McMann, stated that HMO's are no panacea to reducing health care costs, and he questions if they would offer a savings in MT.

Holly Kaleczyc, Montana Psychological Association, supports S.B. 349 because it provides specific inclusion of mental health and drug coverage and creative, innovative opportunities for consumers in health care. She suggested that the bill needs to offer consumer choice in determining health care providers, that financial incentives to individuals agreeing to limit access to necessary health care need to be checked, that governing boards need to have consumer representation, and that it needs to provied consumers with "truth in packaging" provisions. Exhibit # 5.

Chuck Butler, Blue Cross and Blue Shield, endorsed the enabling legislation for HMO's, but stated that the magnitude of the legislation makes it difficult to testify to specifics. He stated that Blue Cross is already by the state Auditor's office and this bill puts Blue Cross under two sets of regulation. He stated that the auditor's office is concerned about the $100,000 start-up fee; but H.S. C. statutes require Blue Cross - Blue Shield to have a one-half million dollar reserve. Blue Cross also has a greater benefit than that mandated by the state for mental health, drug and alcohol care. Some families in Montana are now paying $3,600 a year for health care, and an HMO should contain these costs significantly.

Steve Brown, Lobbyist for Blue Cross - Blue Shield, testified on numerous technical issues in the two bills and a complete list of those technical recommendations is attached. Exhibit # 6.

DISCUSSION OF S.B. NOS. 349 AND 353: Sen. Rassmussen: If neither bill passed, could only the Blue Cross or federally qualified HMO's operate?
Kathy Irigoin: Yes, that it is true; and Blue Cross should not be exempted from this act, because the current laws are very sketchy, and this bill would give adequate guidance.
Sen. Rassmussen: Could other HMO's come in and meet state standards and not federal standards?
Kathy irigoin: The federal act may be repealed, and that would leave only one HMO to operate without this law.

Sen. Eck: How much more does this mandate services that insurance companies don't cover?
Kathy Irigoin: Page 2, Sec. 4-12, of S.B. 349 covers services not specifically required by insurance companies.
Chuck Butler: The bill makes it simpler to include the coverages listed.
Kathy Irigoin: There may be problems in the future with services to be offered.

Chairman Eck appointed a subcommittee of Senators Rassmussen, Jacobson, and Vaughn to meet with legislative researcher Karen Renne, secretary Ellen Nehring, sponsor Darryl Meyer, bill drafters and interested lobbyists to meet Wednesday at 7 P.M. to work on amendments to S.B. 353. S.B. 353 will be amended to include mandated mental health and drug coverage from S.B. 349, and S.B. 349 will be allowed to die in committee.

The meeting adjourned at 3:00 P.M.

Dorothy Eck

CHAIRMAN

ROLL CALL

Public Health, Welfare and Safety COMMITTEE

50th LEGISLATIVE SESSION -- 1987 Date 2-18-87

NAME	PRESENT	ABSENT	EXCUSED
Dorothy Eck	X		
Bill Norman	X		
Bob Williams	X		
Darryl Meyer	X		
Eleanor Vaughn	X		
Tom Rasmussen	X		
Judy Jacobson	X		
Harry H. "Doc" McLane	X		
Matt Himsl	X		
Tom Hager	X		

Each day attach to minutes.

DATE 2-18-87

COMMITTEE ON _____

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
[illegible]		349 353	✓	
John W McMahon	MMA	349 353	✓	
Roland D Pratt	MT Optometric Assoc	353	✓	
Judith H Carlson	NASW	349	✓	
Holly Kaleczyc	MT Psychological Assoc	349	✓	
Bob Phillips	MMA	353	✓	
Steve Waldron	Mental Health Centers	349	X	
Steve Waldron	"	353		X
Armand Altman	Consultant - mental health	349	✓	
Kathy Irigoin	State Auditor	349	amend	
" "	" "	353	X	
Jay McGrath	Mental Health Assoc of MT	349	X	
"	"	353		X
Bill McDonald	Group Health of West Mont	349	X	
		353		X
Ann H. Scott	Rocky Mountain Treatment Center	349 353	X	
STEVE BROWN	Blue Cross - Blue Shield	349	X	
Mona Jamison	RMTC		X	
Mike Mowry	Chemical Dependency Program of MT	349	X	
CHUCK BUTLER	BC+BS	349	X	
RANDY CLINE	" "	349	X	

(Please leave prepared statement with Secretary)

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 2-18-87
BILL NO. SB 349 & 353

SUMMARY COMMENTS
S.B. 353 - Regulation of HMOs
Senate Business and Industry Committee
February 18, 1987

Health maintenance organizations, or HMOs, are a relatively new concept in health care. Because such organizations emphasize prevention of illness and disease, HMOs are frequently promoted as an effective means of health care cost containment. The key difference between an HMO and a health insurance company is that an HMO actually provides health care services, through an assigned physician or provider, for a pre-paid fee, while insurance companies reimburse an individual for costs incurred to obtain medical care.

Montana now has two health maintenance organization operating in the state, and others have indicated their plans to begin similar operations here. The Commissioner of Insurance has requested this bill to ensure both that Montana consumers are protected from companies that may be financially unsound, and also that such organizations provide the number and kind of services that consumers should be able to expect under such a program. This bill will make sure that Montana consumers know the benefits, contractual obligations, and services which are provided.

In order to accomplish these needed protections, the Insurance Department undertook a six-month study to review HMO regulation in five states, including Washington, Idaho, North Dakota, Wisconsin and Utah. Because Montana is one of the last states to enact HMO legislation, this study provided Montana with the benefit of learning from problems experienced by other states. The Department's review found that HMO laws in other states addressed provisions which were not covered in the model act adopted by the National Association of Insurance Commissioner (NAIC). Information obtained from Wisconsin reflected revisions made to their laws following a task force study on HMOs. Information on insolvency laws was obtained from several states, including Idaho, where several HMOs had recently become insolvent. The information and suggested revisions obtained from this research survey were used to make sure that Senate Bill 353 addressed problems encountered by other states in their regulation of health maintenance organizations.

The model act regulating HMOs was adopted by the National Association of Insurance Commissioners (NAIC) in 1982. At that time there were few HMOs operating. Since then, these health organizations have become widespread. Experience has clearly pointed out the need for adequate regulation. The Commissioner's bill encompasses the recommendations from the NAIC model act, together with additional protections found to be necessary through recent experience by other states. This bill also reflects comments and suggestions requested from the Department of Health, which also has requirements that must be met by HMOs in this state.

SENATE HEALTH & WELFARE
EXHIBIT NO 1
DATE 2-18-87
BILL NO ~~S 349~~ S 353

In addition to the increased consumer protections included in this bill, Senate Bill 353 also differs from S.B. 349 in requiring a mandated <u>offer</u> of coverages of mental illness and chemical dependency (alcoholism and drug addiction). S.B. 349 requires mandated <u>coverage</u> of those disabilities.

This bill will provide adequate and fair regulation of health maintenance organizations operating in this state. That regulation will assure consumer protection both in terms of assuring the sound financial condition of the company, and assuring that the services provided and the claims procedures are fair and in the best interests of Montana residents.

SENATE HEALTH & WELF
EXHIBIT NO. 2
DATE 2-18-87
BILL NO 349 & 35

WRITTEN TESTIMONY OF STATE AUDITOR
SENATE BILL 353
February 18, 1987

I. Reason for Senate Bill 353

The State Auditor requested Senate Bill 353 because existing law (specifically 33-22-111, MCA--Montana's freedom of choice of practitioners law) precludes health maintenance organizations (HMOs) from operating in Montana unless they are federally qualified or operated by a health service corporation like Blue Cross/Blue Shield. A health service corporation may operate a HMO in Montana because a Montana Attorney General's opinion holds that health service corporations are not insurance companies and therefore are not subject to the Montana Insurance Code (37 Op. Att'y Gen. 151 (1978)). A federally qualified HMO may operate in Montana because the Federal HMO Act (42 U.S.C. 300e (Supp. V. 1975)) preempts state laws like Montana's freedom of choice of practitioner's law (42 U.S.C. 300e-10(a)(1)(A) through (C)). Because of Montana's freedom of choice of practitioners law, no other HMO may operate in Montana. Senate Bill 353, if passed, would permit any HMO that meets its requirements to operate in Montana.

II. Senate Bill 353 Includes Consumer Protections not Included in Senate Bill 349

Senate Bill 353 includes important consumer protections not included in Senate Bill 349. For example, Senate Bill 353 meaningfully addresses the financial solvency of an HMO. It requires a HMO to have a minimum capital of at least $200,000 (page 33, line 8); whereas, Senate Bill 349 requires a HMO to have a minimum capital of only $100,000 (page 21, line 4). The $200,000 minimum capital required by Senate Bill 353 reflects the $200,000 that the Montana Insurance Code requires disability insurance companies to maintain (33-2-109, MCA). The $200,000 minimum capital required by Senate Bill 353 also takes into consideration that Montana should not require a HMO to have a higher minimum capital requirement than it requires disability insurance companies to maintain.

In terms of consumer protections related to matters other than financial integrity of the HMO, Senate Bill 353 specifies that each evidence of coverage must contain definitions of key terms used in the evidence of coverage (page 20, line 23 through line 6, page 21); clear disclosure of each provision that limits benefits or access to services (page 21, lines 7 through 24); clear disclosure of certain benefits (page 21, line 25 through line 4, page 22); newborn infant coverage (page 22, lines 5 through 7; and page 23, line 20 through line 16, page 24); mandated offer for medical treatment of mental health, alcohol and drug treatment (page 22, lines 8 through

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2-18-87
BILL NO. SB 349 & SB 353

12); conformity with state statutes (page 22, lines 13 through 18); conversion rights (page 22, line 19 through line page 23); and clear disclosure of the amount of money an enrollee shall pay the HMO for basic health care services (page 23, lines 13 through 15).

Senate Bill 353 requires a HMO that denies a claim or initiates disenrollment, cancellation, or nonrenewal to notify the affected enrollee of the right to file a complaint with the HMO (page 27, line 22 through line 1, page 28). Senate Bill 353 also restricts and requires disclosure of the reasons for which and a HMO may disenroll, cancel, or refuse to renew an enrollee (page 35, line 9 through 18, page 36).

Senate Bill 353 requires an individual, partnership, or corporation who acts as an agent selling HMO coverage to be licensed as disability insurance agent like the states of Washington and Idaho do (page 37, line 22 through line 23, page 38). Senate Bill 349 merely provides rulemaking authority to provide for licensing of agents (page 23, line 11 through line 2, page 24).

Under both Senate Bill 353 and Senate Bill 349, a public or private employer that employs 25 or more employees and offers them health benefit plans must also make available to and inform its employees of the option to enroll in at least one HMO (page 53, lines 5 through 18 of SB 353; and page 35, line 16 through line 3, page 36 of SB 349). Unlike Senate Bill 349, Senate Bill 353 protects Montana employers by not requiring them to pay more for health benefits as a result of the having to give employees a dual choice (page 53, line 19 through line 5, page 54).

III. The Legislature is the Appropriate Body to Determine Whether Coverage for Mental Illness, Alcoholism, and Drug Addiction Should Be Mandated

Senate Bill 353 merely requires a HMO to <u>offer</u> coverage of mental illness, alcoholism, and drug addiction. Senate Bill 349, on the other hand, requires coverage of mental illness, alcoholism, and drug addiction. The State Auditor will not oppose efforts to amend Senate Bill 353 to mandate coverage of mental illness, alcoholism, and drug addiction, if the Legislature believes coverage for those items should be mandatory like it is for insurance companies.

IV. Senate Bill 353 Incorporates Suggestions of the Department of Health; Whereas, Senate Bill 349 Does Not

Senate Bill 353 incorporates suggestions of the department of health, which will regulate and review quality of care in HMOs operating in Montana because the insurance department lacks the expertise to perform those duties. Senate Bill 349 does not provide the department of health adequate authority to

regulate quality of care in HMOs. For example, Senate Bill 349 does not authorize the department of health to implement or enforce the HMO Act (page 31, line 4 through line 24, page 32 of SB 349). In addition, Senate Bill 349 does not include authority for the director of health to contract; whereas, Senate Bill 27 does (page 52, lines 1 through 7 of SB 353).

Senate Bill 353 gives the department of health 90 days (with an optional extension of 30 days) to certify a HMO application to the insurance commissioner (page 13, line 14); whereas, Senate Bill 349 provides only 30 days (page 8, line 10). Senate Bill 353 clarifies that the HMO Act does not exempt HMO activities from applicable certificate of need requirements (page 18, lines 2 through 5; page 40, lines 1 through 4; and page 50, lines 21 through 24). Senate Bill 349 does not address certificates of need for HMOs.

Senate Bill 353 provides that examination expenses are statutorily appropriated to the department of health as provided in 17-7-502, MCA (page 41, line 25 through line 5, page 42). Senate Bill 353 provides the department of health rulemaking authority; whereas, Senate Bill 349 does not. Senate Bill 353 merely permits the director of health to attend and participate in an administrative hearing instituted by the insurance commissioner (page 46, lines 10 through 11); whereas, Senate Bill 349 requires attendance and participation by the director of health in administrative hearings of the insurance commissioner (page 30, lines 1 through 3). Senate Bill 353 authorizes the director of health to assess fees necessary and adequate to cover the expenses of his functions, other than examinations, and statutorily appropriates those fees as provided in 17-7-502, MCA (page 47, lines 20 through 24). Senate Bill 349 does not address fees to cover the expenses of the director of health's functions.

V. Senate Bill 353 Accommodates the Small Insurance Department Staff; Whereas, Senate Bill 349 Does Not

Senate Bill 353 requires an applicant for a HMO certificate of authority to provide information that will assist the small insurance department staff in corresponding with the applicant (page 6, lines 1 through 12). It also permits an HMO to file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract to decrease the amount of paper the part-time staff person must spend to review contracts and to accommodate the shortness of storage space in the insurance department (page 7, lines 11 through 13). Senate Bill 353 gives the insurance department 180 days after receipt of the certified application for a HMO certificate of authority from the department of health to issue or deny a certificate of authority (page 14, lines 4 through 7); whereas, Senate Bill 349 gives the insurance department only 30 days (page 8, line 10). Under present insurance law, the insurance department is

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2-18-87
BILL NO. SB 349/353

under no time limitation to approve or deny an application for a certificate of authority.

In addition, Senate Bill 353 includes no "deemer clauses"; whereas, Senate Bill 349 does. For example, Senate Bill 349 provides that (1) if the commissioner does not disapprove an exercise of power by an HMO within 30 days after the HMO notification, exercise of the power is deemed approved (page 11, lines 17 through 19 of SB 249); and (2) if the commissioner does not approve a form within 30 days of the filing of the form, it is deemed approved (page 15, lines 19 through 20). The part-time staff person who reviews and approves forms may not always have time to review a form within 30 days of filing. For example, a form may be lost in the mail, or the part-time form reviewer may become ill within 30 days of filing. The "deemer clause" of Senate Bill 349 leaves unclear whether a form is deemed approved even if the insurance department has communicated problems with the form to the filer but has not specifically disapproved it. Therefore, a "deemer clause" does not serve the best interests of Montana insurance consumers.

VI. Technical Problems with Senate Bill 349

Senate Bill 349 does not amend 33-22-111, MCA, Montana's freedom of choice of practitioners law, which effectively precludes the operation of HMOs in Montana except those HMOs that are either federally qualified or operated by health service corporations. Senate Bill 349, therefore, discriminates against non-health service corporation HMOs and non-federally qualified HMOs. Senate Bill 349 does not enable the operation of all HMOs in Montana.

SENATE HEALTH & WELFARE
EXHIBIT NO. 2
DATE 2-18-87
BILL NO. SB 349 & 35

BLUE CROSS & BLUE SHIELD OF MONTANA

Monies recovered on Valid Complaints

1986	1985	1984	1983
918.00	1266.00	975.00	242.65
139.25	18.60	736.00	167.00
106.80	25.00	120.00	186.00
1466.90	359.50	173.00	9244.00
87.50	261.60	788.00	361.54
221.44	226.00	225.00	2730.00
722.18	32.00	51.00	443.00
151.24	800.00	32.00	4718.00
1487.50	25.00	111.00	479.00
2089.60	2251.00	256.00	281.00
1208.00	543.00	3467.00	268.00
4750.00	247.00		163.00
1456.50	6054.70		3769.00
159.60			106.25
162.37			1374.00
1088.64			3683.00
1088.92			280.00
2948.66			365.00
127.90			499.00
396.10			1712.00
34.50			107.00
2377.29			1091.00
795.00			2866.00
23,983.89			1627.00
			997.00
			2997.00
			646.00
			315.20
			376.00
			2718.00
			1537.00
			812.00
			3479.00
			1561.00
			192.00
			259.00
			826.00
			944.00
			405.00
			348.00
			55174.64

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LEGISLATIVE PLATFORM
Mental Health Association of Montana
1986 and 1987

Adopted by
Board of
Directors
[illegible]

The Mental Health Association of Montana is a statewide broad-based volunteer organization working to bring about the prevention of mental illness, promotion of mental health and improved services for individuals who are mentally ill. We recognize the scope of the economy is unpredictable, but to advocate for quality mental health care and the rights of those in need, the Association supports the following in 1986 and 1987.

FUNDING ISSUES:

1. We support adequate funding for appropriate facilities to maintain [illegible] care at state [illegible] mentally ill.

2. In times of economic difficulties, we demand at least the same [illegible] dollars that is now funding, used to obtain the most efficient [illegible] toward "search cost" patient [illegible] to [illegible] and to direct with regard to other services [illegible] willing.

3. We encourage [illegible] the Mental Health [illegible] to [illegible] to locate [illegible] to meet [illegible] and needs [illegible] by state law.

4. It is essential that there be funding to allow the [illegible] emotionally disturbed children and youth to receive [illegible]

5. We support the funding for appropriate psychiatric services [illegible] persons of all ages [illegible] the state's [illegible] at all [illegible] levels.

6. We recommend that additional funding be available to [illegible] Hospital, [illegible] mental health centers will be [illegible] the requirements of law but provide additional opportunities [illegible] clients.

7. We encourage [illegible] to [illegible] that help the mentally ill.

JUDICIAL ISSUES:

1. MENTAL COMMITMENT ACT. The MHAM supports the [illegible] bodied in HB176 (1985 legislative session) to [illegible] treatment to mentally ill persons who are not [illegible] under the present commitment law but are in need of treatment and unable to make a rational decision to seek such, providing protections for the person's civil rights in a way [illegible] are comparable to the current law.

2. WEEKLY MEDICATION REVIEW. The MHAM opposes changing the law requiring the weekly review of medications. We feel a change to "at least once in [illegible] would weaken the medication review requirement and leave consumers of mental health services at risk. We would recommend instead that treatment teams do monthly reviews of medications along with their comprehensive review of treatment plans.

Support SB 349 or amend SB 349 to include Medicaid reimbursable

SENATE HEALTH & WELFARE
EXHIBIT NO. 3
DATE 2-18-87
BILL NO. SB 349

3. DUTY TO WARN: We support the concept of limiting the liability of licensed and/or certified professional persons in a situation when a client has made a serious threat of physical violence on the condition that any proposed legislation contain appropriate and sufficient protection for the client and the licensed and/or certified professional person alike.

4. PSYCHOLOGIST DEFINITION: We support the substitution of the title "Psychological Associate" for use with employees in state institutions who are currently titled psychologists but are non-licensed.

5. CONSUMER MEMBERSHIP ON BOARDS: We are supportive of any legislation that gives mentally ill consumers and family members more direct and active voices on boards that deal with mental health issues and that receive significant amounts of public funds.

SERVICE ISSUES:

1. HEALTH MAINTENANCE ORGANIZATIONS: The MHAM supports the HMO concept providing that each HMO is:

   A. Integrated into the total health delivery system.
   B. Able and willing to serve the community as a whole.
   C. Open to and guided by the needs of the community of consumers and providers for a comprehensive mental health system.
   D. Able and willing to provide adequate mental health services to a broad spectrum of the community, where feasible by contract with a community mental health center or other comprehensive community mental health service provider.

2. MANDATED INSURANCE:

   A. We support increased benefit coverage in mandated insurance up to levels applicable to physical illness.
   B. We encourage elimination of the interdisciplinary team requirement for reimbursement by third parties.

CHILDREN AND YOUTH ISSUES:

We support adequate and appropriate treatment of all emotionally disturbed children and youth and are watching all related issues.

MISCELLANEOUS ISSUES:

1. SUPERINTENDENT OF MONTANA STATE HOSPITAL: We support deleting the statutory requirements for hiring of the superintendent at Montana State Hospital.

2. CERTIFICATE OF NEED: We support the enactment of workable certificate of need process, which is more responsive to mental health needs.

NASW National Association of Social Workers

MONTANA CHAPTER

TESTIMONY ON SB 349 AN ACT TO REGULATE HEALTH SERVICE ORGANIZATIONS

February 18, 1987
Senate Public Health Committee

My name is Judith H. Carlson representing the Montana Chapter, National Association of Social Workers. We strongly support SB 349. We suggest that the committee approve this bill because of the need to regulate the health maintenance organizations according to the existing insurance laws of this state. Our present law requires mental health coverage on a mandated basis. We support the inclusion of mandated mental health coverage by health maintenance organizations. SB 349 does just that.

We appreciate the fact that the State Auditor and Insurance Commissioner, Andrea Bennett, did include social workers and other mental health groups in her planning for HMO regulation. We are at a loss as to why she has not chosen to include mandated mental health coverage in her bill because we have made it clear from the beginning that this was a "must" for us.

Since you have two bills before you which deal with the same subject, we urge you to support SB 349 because of its mandated mental health coverage.

Thank you very much.

Judith H Carlson

SENATE HEALTH & WELFARE
EXHIBIT 5
DATE 2-18-87
BILL NO 295 & 253

Madame Chairman. Members of the Committee.

My name is Holly Kaleczyc.

I am here today to represent the Montana Psychological Association in general support of SB 349, sponsored by Senator Regan and Senator Himsl.

The Montana Psychological Association believes that HMOs provide new opportunities for the the delivery of cost-effective, innovative health care.

We support SB 349 because it clearly defines "Basic health care services" to include mental health services and services for alcohol or drug abuse as required services.

Mental health care is a critical part of health care and recent documented studies have shown that the use of medical services decreases when appropriate mental health services are provided.

Mental health treatment saves health dollars.

In fact, as many as 60% of total patient visits to physicians are due to emotional problems, not physical ailments.

The two bills before you, which authorize and regulate Health Maintenance Organizations are enormously complicated.

As you deliberate, we ask that you support HMO legislation that mandates mental health coverage.

We also suggest that you keep the following questions in mind:

1. Is the bill written for the benefit of consumers or for the benefit of someone else?

2. Does it prohibit discrimination and assure consumer choice of mental health providers and other specialists?

3. Does it allow financial incentives to individuals if they agree to limit access to necessary health care?

4. Who sits on the governing board? Just physicians? Is it multidisciplinary? Are consumers represented?

5. Does it provide consumers with "truth-in-packaging"---full, clear, easy to understand information on benefit levels, cost cutting strategies, limitations, and the utilization/quality mechanisms operating inn HMOs?

Thank you for your hard work and attention to this important legislation.

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 2-18-87
BILL NO SB 349 & 353

Important Differences between SB 349 and SB 353

1. Basic Health Care Services

   Recommendation: amend SB 353 to include mental health services and services for alcohol and drug abuse

2. Provider (SB 353 lists specific occupational groups)

   Recommendation: SB 349 is broader and would prevent future bills to amend in other specific occupational groups

3. Application for certificate of authority

   Recommendation: SB 349 appears to cover more territory and allows more flexibility on the part of the commissioner, but SB 353 includes two items that tend to protect consumers: pp. 7-8, on certain provisions that will appear in enrollees' contracts and on marketing surveys. SB 353 also includes items that the Puget Sound HMO person felt were damaging, such as projected enrollments in the area and details on administrative services (pp. 9-10). SB 349 does contain a residual category on p. 6.

4. Modifications to plan

   Recommendation: SB 353 details types of modification that must be filed, but neither bill provides for a hearing on disapproval of modification

5. Certification by health department

   Recommendation: SB 353 gives DHES 90 days to determine whether an application should be approved, compared with 30 in SB 349. Steve Brown questioned whether DHES could make this determination at all.

6. Issuance of certificate of authority by commissioner

   Recommendation: SB 353 gives the commissioner another 90 days to issue a certificate, compared with 30 in SB 349; the total lapse is 270 days in SB 353, compared with 60 in SB 349.

   Both bills require a judgment of the applicant's character (p. 8 in SB 349), which was criticized by Steve Brown

SENATE HEALTH & WELFARE
EXHIBIT NO. 5
DATE 2-18-87
BILL NO. SB 349 & 353

7. Certificate of need requirement

Recommendation: SB 349 does not address Certificate of Need but SB 353 makes HMOs subject to any CON applicable CON requirements (p. 3, line 23 - this CON bill specifically includes HMOs.

8. Enrollee participation in major policy decisions]

Recommendation: Both bills have the same provision, which Steve Brown found objectionable (see p. 12 in SB 349)

9. Evidence of coverage provisions

Recommendation: SB 353 includes a great many more provisions that must be included, though the general language in SB 349 could be interpreted as the same coverage (p. 13 in SB 349 vs. pp. 21-24 in SB 353)

10. Charges

Recommendations: SB 353 prohibits changes in charges to enrollees more than once a year unless "actuarily justified." This may or may not be additional consumer protection.

11. Annual statements

Recommendations: SB 353 requires an annual financial statement, whereas SB 349 merely requires a report. SB 353 requires a fee to accompany the statement and provides a penalty for failure to file.

12. Information to enrollees

Recommendation: Both bills require "prompt" notification to enrollees; Steve Brown suggested that a specific time frame should be included.

13. Complaint systems

Recommendation: Both bills require commissioner approval, as well as review, of a complaint system, but SB 349 also requires DHES consultation. SB 353 establishes some features of a complaint system, involving notification of enrollees and a time limit for response, that don't appear in SB 349.

SENATE HEALTH & WELFARE
EXHIBIT NO. 1
DATE 2-18-83
BILL NO SB 349-353

14. Investments

Recommendation: SB 349 seems to allow more leeway in investments, though both bills refer to commissioner discretion.

15. Protection against insolvency

Recommendation: Except for the larger capital requirement in SB 353, bills appear to contain the same provisions. (See pp. 17-21 in SB 349 vs. pp. 29-33 in SB 353). Steve Brown said SB 349 was preferable but still too restrictive.

MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE
MONTANA STATE SENATE

February 20, 1987

The meeting of the Senate Public Health, Welfare and Safety Committee was called to order by Chairman Dorothy Eck on February 20, 1987, at 12:40 P.M. in Room 325 of the State Capitol.

ROLL CALL: All members were present, except for Senator Tom Hager.

FURTHER CONSIDERATION OF S.B. 353: Sen. Tom Rassmussen explained the action of the subcommittee and stated that the subcommittee blended the two bills together.

Karen Renne explained the new amendments to S.B. 353, which included recommended sections of S.B. 349. See amendments on attached Standing Committee Report.

David Evenson, Montana University System, stated that Commissioner of Higher Education foresees problems with Section 29 on dual choice. Younger, healthy pelple would probably choose to join an HMO, while older people would stay in the same indemnity program at an increased cost to the employer. They would like to see employers have the ability to negotiate with HMO's and place them into a bid situation.

Sen. Rassmussen: I would like Blue Cross to comment on the last amendment.
Ans: Chuck Butler: The Federal HMO Act, under which HMO's seek to be federally qualified, can go in and mandate that the University system consider their program. Under this act, any state HMO could do that, too.
Mona Jamison, Lobbyist, Rocky Treatment Center, stated that the committee should think about the Federal Government requiring that HMO coverage be mandatorially offered. If this bill passes, all employers with twenty-five employees or more will have to offer HMO coverage. Because the young and healthy will probably choose an HMO and the older, less healthy will need to stay with the regular health insurance industry, this could have quite an impact on the Montana health insurance industry. The committee needs to consider this. No one has yet had an opportunity to examine this.

Sen. Eck: Does this mean that every employer group must offer this?
Kathy Irigoin: Yes, if the employer has twenty-five or more employees. The Federal HMO Act does have this provision, which the Federal Government provided to get HMO's off the ground. The Federal Act may be repealed.

Sen. Rassmussen: I would like to move the additional amendments: Page 53, lines 5-20. We should have the option in our law of not mandating employers, but providing them with flexibility.
Chuck Butler: You would not have to offer a Federally qualified HMO, if you have a choice.
Sen. Eck: Would employers have to offer HMO's to employers, if they have twenty-five employees?

Chuck Butler: If HMO's are operating in the area, yes.

Sen. Jacobson: I would like to speak in favor of Sen. Rassmussen's amendment. I am more comfortable with it.

Chairman Eck called for the question and the amendments on Page 53 were adopted unanimously.

Sen. Norman: Concerning Amendment 33, P. 52, Section 37, what is the intent of the committee? Who will decide quality care? Is the state going to do that? They don't want to and can't. It doesn't work.

Ans: Dr. John Drynan, DHES: Dr. Norman is correct. The Department of Health would have to contract with a group, probably from a hospital anyway. The DHES is not qualified to do quality care checks, and it is very expensive for them to contract this out. The DHES does quality control on facilities now when they apply for licensing, so they would be duplicating work now done by peers.

Kathy Irigoin: Quality of care is critical in regulation of HMO's, if the goal is to cut costs. The quality is important to the consumer, and if you cut the amount and quality of services, you can endanger the consumer. An outside observer needs to oversee an HMO, like the Department of Health. The State Auditor realizes that the Dept. of Health may not have the staff to do quality control. P. 52, Section 27, lines 1-7 gives the Dept. of Health the authority to contract out.

Sen. Eck: Are there any HMO's operating in Montana using facilities not licensed by the Dept. of Health?
Ans: Chuck Butler: No.

Sen. Norman: We are all interested in quality. Will this bill and the Dept. of Health provide quality supervision?
Kathy Irigoin: The Department of Health can contract with someone, if not the Department of Health, then there is a national organization who will come in and look at facilities and services, which other states are using.

Dr. Drinan: This bill requires the Dept. of Health to put on a staff of at least two auditors, and these need to be funded by this committee.

Steve Brown: There is also a problem with Section 21 in that an HMO has no grounds to challenge the DHES on denial of a certificate of authority.

Sen. Eck: I have a question on Sec. 15, Amendment # 25?
Karen Renne: That is controversial.
Chuck Butler: That is the guts of an HMO, and # 25 takes the guts out of the program.

ROLL CALL

Public Health, Welfare and Safety COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date 2-20-87

NAME	PRESENT	ABSENT	EXCUSED
Dorothy Eck	X		
Bill Norman	X		
Bob Williams	X		
Darryl Meyer	X		
Eleanor Vaughn	X		
Tom Rasmussen	X		
Judy Jacobson	X		
Harry H. "Doc" McLane	X		
Matt Himsl	X		
Tom Hager			

Each day attach to minutes.

DATE 2-20-87

COMMITTEE ON _____

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
BERGSTROM	MT. STATE FIREMENS ASSOCIATION	SB 351	✓	
Don INGELS	MT Chamber of Commerce	351		
Don Willems	Dept. of Health & Env. Sci.	351		
GEORGE OCHENSKI	MT. ENV. INF. CNTR	351	✓	
T Zaenkert	MT Med Assn	371		
Roland D Pratt	MT Optometric Assoc	371		
Ashe Howe	MT Dept of Health	351		
Tom Hopgood	Health Ins. Assoc. of Amer	371	✓	

(Please leave prepared statement with Secretary)

MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

February 20, 1987

The meeting of the Senate Public Health, Welfare and Safety Committee was called to order by Chairman Dorothy Eck on February 20, 1987, at 7:40 P.M. in room 410 of the State Capitol.

ROLL CALL: All members were present, except for Senators Hager and Himsl.

FURTHER CONSIDERATION OF SENATE BILL NO. 351: Sen. Eck: The question seems to be whether the member should be assigned to the EQC, to an executive agency, or at all.
Brace Hayden, Western Interstate Energy: It could be handled by either the executive branch or the legislative branch.

Sen. Rassmussen: Do you feel that the executive branch isn't monitoring this adequately at this time?
Brace Hayden: The executive branch does many functions described in the bill, but it can't do all the functions in the bill. It is not a member of any western compact. WIE is simply a federal agency that sends out information.

Sen. Rassmussen: Would the Department of Health be the appropriate agency to have involved?
Mr. Hayden: The bill would have a member of th legislative branch participate in gathering information.
Dr. Drinan: The biggest problem for the department of Health is being spread too thin. We may need another staff person, and the only person educationally qualified in the state is Larry Lloyd. When we helped to design the bill, we thought it would be more appropriate to have a legislative representative on the board rather than a state offical because he will probably to back to the legislature for action.

Brace Hayden: We get one notice a week of radioactive material going through the state, and the Governor needs to know this. This person will rely on the expertise of the Health Department.

Sen. Eck: Should Sec. 2, P.7, be deleted at this time?
Dr. Drinan: We could take this to the House where we could work out the appropriation further.

Sen. Jacobson moved to delete everything in the title following the word "management" on Line 6 and Section 2.

Sen. Rassmussen: Are we letting the House decide? I think it is appropriate for the Department of Health to handle this.
Dr. Drinan: We are doing that already and I would have no problem with that, if that would satisfy the intent of the bill.

George Ochenski, MEIC: Should Sen. Walker speak about what you are going to do to replace the striken section?
Sen. Rassmussen: I would make a substitute motion to plug in the DHES in place of the EQC and accept the DHES amendment.
Dr. Drinan: Sen. Walker does not object to that.

ACTION ON S.B. 351: The amendments proposed by the DHES were moved (by Sen. Rassmussen) and passed unanimously.

Sen. Rassmussen moved that S.B. 351 DO PASS AS AMENDED. The vote in favor was unanimous.

FURTHER ACTION ON S.B. 371: Sen. Regan proposed some additional amendments to S.B. 371. They incluced amending the title of the bill, amendments to Lines 19-22, a new Sec. 4, P.2. Chairman Eck called for a motion to reconsider the afternoon action. Sen. Williams so moved. The motion carried unanimously.
Sen. Jacobson moved that the amendments be adopted. The motion carried unanimously.
Sen. Jacobson moved that S.B. 371 DO PASS AS AMENDED. The motion carried unanimously.

ACTION ON S.B. 353: Karen Renne addressed the amendments to the amendments on Sections 5 and 7. Steve Brown, BC-BS, stated that that is proprietary information which is Blue Cross's objection. There could be a confidentiality provision for that information, but the information may still have to be disclosed, enabling another company to take advantage of the work a previous company has done.

Jim Bourhardt, Chief Examiner, Auditor's Office, stated that they would like to know if the companies have reasonable plans, especially if they are a new start-up company. confidentiality of information will be a problem, if information on what one company does is available to other companies. Large companies will have the advantage in that they will have computor and auditing systems already available.

Steve Brown stated that if you lay out what you are charging a patient, that will be very valuable information to a competitor. Kathy Irigoine, Auditor's Office, stated that all that information is not required, but that other information like the premium charge will be. North Dakota has adopted the NAIC model, which is where this language came from.

Sen. Rassmussen moved to keep in thelanguage to delete Amendment No. 7. The motion failed.

Amendment No. 25 is the "guts" of an HMO and they need to have it to operate. That amendment died for lack of a motion.

Sen. Rassmussen: What about quality of care?

Kathy Irigoine: Amendment # 9 takes care of this concern.

Sen. Jacobson moved that the amendments receive a DO PASS. The motion carried. Sen. Jacobson moved that S.B. 353 DO PASS AS AMENDED. The motion carried unanimously.

Sen. Rassmussen moved that the committee adopt the Statement of Intent. The motion carried unanimously.

Chairman Eck adjourned the meeting at 8:30 P.M.

Dorothy Eck

CHAIRMAN

ROLL CALL

Public Health, Welfare and Safety COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date 2-20-87
7:30 PM

NAME	PRESENT	ABSENT	EXCUSED
Dorothy Eck	X		
Bill Norman	X		
Bob Williams	X		
Darryl Meyer	X		
Eleanor Vaughn	X		
Tom Rasmussen	X		
Judy Jacobson	X		
Harry H. "Doc" McLane	X		
Tom Hager			
Matt Himsl			

Each day attach to minutes.

ROLL CALL VOTE

SENATE COMMITTEE Public Health, Welfare and Safety

Date 2-20-87 Bill No. 353 Time 8:23

NAME	YES	NO
Dorothy Eck		X
Bill Norman		X
Bob Williams		X
Darryl Meyer		
Eleanor Vaughn	X	
Tom Rasmussen	X	
Judy Jacobson		X
Harry H. "Doc" McLane	X	
Matt Himsl		
Tom Hager		

Ellen Nehring
Secretary

Dorothy Eck
Chairman

Motion: To delete Amendment 7.

1987

STANDING COMMITTEE REPORT

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SCRSB353

February 21, 1987

MR. PRESIDENT

We, your committee on Public Health, Welfare, and Safety

having had under consideration Senate Bill No. 353

first white reading copy (color)

REGULATE HEALTH MAINTENANCE ORGANIZATIONS

Respectfully report as follows: That Senate Bill No. 353

BE AMENDED AS FOLLOWS:

1. Title, line 7.
Following: "SECTIONS"
Strike: "17-7-502 AND 33-22-111"
Insert: "33-1-102 AND 33-1-704"

2. Title, line 8.
Strike: "IMMEDIATE"

3. Page 2, following line 3.
Insert: "(i) care and treatment of mental illness, alcoholism, and drug addiction;"
Renumber: subsequent subsections

4. Page 4, following line 9.
Insert: "(12) "Plan" means a health maintenance organization operated by an insurer or health service corporation as an integral part of the corporation and not as a subsidiary"
Renumber: subsequent subsections

5. Page 5, lines 14 and 15.
Following: "30 days"
Strike: "of [the effective date of this act]"
Insert: "after the effective date of rules adopted by the commissioner and the department of health as provided in [section 20]"

DO PASS

DO NOT PASS

CONTINUED

Chairman.

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February 21, 1987
19

6. Page 8, lines 16 through 22.
Strike: subsection (viii) in its entirety
Renumber: subsequent subsections

7. Page 10, lines 19 through 24.
Strike: subsection (xvi) in its entirety
Renumber: subsequent subsections

8. Page 11, line 23.
Following: "may"
Insert: ",after notice and hearing,"

9. Page 13, lines 5 and 6.
Following: "health care"
Strike: "processes and outcomes"
Insert: "availability, accessibility, and continuity of service"

10. Page 13, line 14.
Following: "within"
Strike: "90"
Insert: "60"

11. Page 13, line 19.
Following: "shall"
Insert: ",after notice and hearing,"

12. Page 14, line 3.
Following: "initial"
Strike: "90-day"
Insert: "60-day"

13. Page 14, lines 12 and 13.
Following: "competent"
Strike: remainder of line 12 through "reputation" on line 13
Insert: "and trustworthy"

14. Page 15, lines 24 and 25.
Following: "investigation,"
Strike: "is contrary to the public interest"
Insert: "violates any provision of [sections 1 through 29] or rules adopted by the commissioner or the department of health"

CONTINUED

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15. Page 22, line 8.
Following: "provision"
Strike: "offering"
Insert: "requiring"

16. Page 26, line 5.
Strike: "Each"
Insert: "Unless it is operated by an insurer or a health service corporation as a plan, each"

17. Page 26, line 23.
Following: "may"
Insert: ",after notice and hearing,"

18. Page 27, line 6.
Following: "through 29)"
Insert: ", including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan"

19. Page 27, line 9.
Strike: "promptly"
Following: "enrollees"
Strike: "notice"
Insert: "30 days' advance notice, in writing,"

20. Page 29, lines 4 and 5.
Following: "prescribed in"
Strike: "rules adopted by the commissioner"
Insert: "Title 33, chapter 1, part 8"

21. Page 33, line 7.
Following: "(9)"
Strike: "Each"
Insert: "Unless it is operated by an insurer or a health service corporation as a plan, each"

22. Page 34, lines 1 through 5.
Strike: subsection (a) in its entirety
Renumber: subsequent subsections

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23. Page 35, line 25.
Following: "organization;"
Strike: "or"

24. Page 35, following line 25.
Insert: "(e) has violated rules of the health maintenance organization stated in the evidence of coverage;
(f) has violated rules adopted by the commissioner for enrollment in a health maintenance organization; or"
Renumber: subsequent subsection

25. Page 36, lines 20 and 21.
Strike: "except failure to pay required premiums"
Insert: "not listed in subsection (3) or provided in rules adopted by the commissioner"

26. Page 36, line 25.
Following: "period of"
Strike: "36"
Insert: "12"

27. Page 37, line 2.
Strike: "except failure to pay required premiums"
Insert: "not listed in subsection (3) or provided in rules adopted by the commissioner"

28. Page 40, line 12.
Following: "examine the"
Strike: "quality"
Insert: "availability, accessibility, and continuity"

29. Page 43, line 2.
Following: "director"
Insert: ",after notice and hearing,"

CONTINUED

February 21, 1987 19

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38. Page 47, line 3.
Following: "(3)"
Strike: remainder of subsection (3) in its entirety
Insert: "Where notice and hearing are required with regard to actions taken by the commissioner under [sections 1 though 29], the requirements of 33-1-314 through 33-1-316 and Title 33, chapter 1, part 7, apply, except that the formal rules of pleading and evidence must be observed. To the extent that 33-1-314 through 33-1-316 and Title 33, chapter 1, part 7, do not address the notice and hearing requirements of [sections 1 through 29], the provisions of Title 2, chapter 4, parts 6 and 7, apply.
(4) Where notice and hearing are required with regard to actions taken by the director under [sections 1 through 29], the provisions of Title 2, chapter 4, parts 6 and 7, apply."

31. Page 47, lines 21 through 24.
Following: "functions"
Strike: ", other than examinations,"
Following: "chapter."
Strike: remainder of subsection (3) in its entirety
Insert: "These fees must be deposited in the general fund."

32. Page 48, following line 2.
Insert: "after notice and hearing"

33. Page 48, lines 8 through 11.
Following: "citation."
Strike: remainder of subsection (1) in its entirety

34. Page 48, line 12.
Following: "(2)"
Strike: "(a)"
Renumber: subsections (i) through (iii) as (a) through (c)

35. Page 48, line 25, through line 6 on page 49.
Strike: subsection (b) in its entirety

36. Page 52, line 6.
Following: "accepted"
Insert: "or rejected"

37. Page 53, lines 5 through 18.
Strike: subsection (1) in its entirety

CONTINUED

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38. Page 53, line 19.
Strike: "(2)"
Following: "state"
Insert: "that offers its employees the option to enroll in a health maintenance organization and an employee benefit fund in this state that offers its members the option to enroll in a health maintenance organization"

39. Page 53, lines 20 and 21.
Following: "benefits"
Strike: "as a result of the application of this section"
Insert: "provided by the health maintenance organization"

40. Page 54, lines 3 and 4.
Strike: "(a)" and "(b)"
Insert: "(1)" and "(2)" respectively

41. Page 54, line 7, through line 7 on page 58.
Strike: sections 30 and 31 in their entirety
Insert: "Section 30. Section 33-1-102, MCA, is amended to read:

"33-1-102. Compliance required -- exceptions -- health service corporations. (1) No person shall transact a business of insurance in Montana or relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) No provision of this code shall apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code shall not apply to health service corporations to the extent that the existence and operations of such corporations are authorized by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and operations of such organizations are authorized by [this act]."

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February 21, 1987 19.....

Section 31. Section 33-1-704, MCA, is amended to read:

"33-1-704. Hearing procedure. (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an original party thereto and whose pecuniary interests will be directly and immediately effected by the commissioner's order made upon the hearing.

(4) ~~Formal~~ Except as provided in [section 21], rules of pleading or evidence need not be observed at any hearing.

(5) Upon written request reasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings.""

41. Page 58, lines 15 and 16.
Following: "applicability."
Strike: "This act is"
Insert: "Section 20 and this section are"
Strike: "and" on line 16
Insert: ". This act"

AM AS AMENDED,
DO PASS

.....

Senator Eck

February 21, 1987

MR. PRESIDENT,

WE, YOUR COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY HAVING HAD UNDER CONSIDERATION SENATE BILL NO. 353, ATTACH THE FOLLOWING STATEMENT OF INTENT:

STATEMENT OF INTENT

Senate Bill No. 353

A statement of intent is required for this bill because:

(1) it authorizes the commissioner of insurance of the state of Montana (commissioner) and the department of health and environmental sciences to adopt, after notice and hearing, reasonable rules necessary or proper to effectuate sections 1 through 29;

(2) section 3 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner describing material modifications of information required in an application for a certificate of authority if the commissioner considers the information unnecessary; and

(3) section 5 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner before exercising the powers granted in subsection (1)(a), (1)(b), or (1)(d) if the commissioner believes exercising those powers will have de minimis effect. The legislature expects the commissioner to make only reasonable rules necessary to effectuate or aid the effectuation of sections 1 through 29. The legislature does not authorize the commissioner to adopt rules that extend, modify, or conflict with either any law of this state or any reasonable implications of those laws. If reasonably possible, the commissioner shall set forth a proposed rule or amendment to a rule in or with the required notice of hearing. No rule or amendment to a rule by the commissioner is effective until it has been on file in the commissioner's office for at least 10 days.

In adopting rules prescribing investment regulations, the commissioner shall use the NAIC Model Health Maintenance Organization Investment Guidelines.

The commissioner and the department are urged to look to regulations adopted by the state of Minnesota in implementing chapter 62D of the Minnesota insurance code.

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APPROVED BY COMMITTEE
ON PUBLIC HEALTH, WELFARE
& SAFETY

STATEMENT OF INTENT

SENATE BILL 353

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because:

(1) it authorizes the commissioner of insurance of the state of Montana (commissioner) and the department of health and environmental sciences to adopt, after notice and hearing, reasonable rules necessary or proper to effectuate sections 1 through 29;

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(3) section 5 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner before exercising the powers granted in subsection (1)(a), (1)(b), or (1)(d) if the commissioner believes exercising those powers will have de minimis effect. The legislature expects the commissioner to make only reasonable rules necessary to effectuate or aid the effectuation of sections 1 through 29.

The legislature does not authorize the commissioner to adopt rules that extend, modify, or conflict with either any law of this state or any reasonable implications of those laws. If reasonably possible, the commissioner shall set forth a proposed rule or amendment to a rule in or with the required notice of hearing. No rule or amendment to a rule by the commissioner is effective until it has been on file in the commissioner's office for at least 10 days.

In adopting rules prescribing investment regulations, the commissioner shall use the NAIC Model Health Maintenance Organization Investment Guidelines.

The commissioner and the department are urged to look to regulations adopted by the state of Minnesota in implementing chapter 62D of the Minnesota insurance code.

SECOND READING
SB 353

SENATE BILL NO. 353

INTRODUCED BY MEYER, LORY, BENGTSON, MILLER, MCLANE, SANDS

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE FORMATION AND OPERATION OF HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS ~~17-7-502--AND--33-22-111~~ 33-1-102 AND 33-1-704, MCA; AND PROVIDING AN ~~IMMEDIATE~~ EFFECTIVE DATE AND AN APPLICABILITY PROVISION."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Short title. This act may be cited as the "Montana Health Maintenance Organization Act".

NEW SECTION. Section 2. Definitions. As used in [sections 1 through 29], unless the context requires otherwise, the following definitions apply:

(1) "Agent" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(2) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

(e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to [section 8(3)(e)];

(F) CARE AND TREATMENT OF MENTAL ILLNESS, ALCOHOLISM, AND DRUG ADDICTION;

~~(f)~~(G) diagnostic laboratory and diagnostic and therapeutic radiologic services; and

~~(g)~~(H) preventive health services, including:

(i) immunizations;

(ii) well-child care from birth;

(iii) periodic health evaluations for adults;

(iv) voluntary family planning services;

(v) infertility services; and

(vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction.

(3) "Commissioner" means the commissioner of insurance of the state of Montana.

(4) "Department of health" means the department of health and environmental sciences provided for in 2-15-2101.

(5) "Director" means the director of the department of health and environmental sciences provided for in 2-15-2102.

(6) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

(7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(8) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

(9) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(10) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers.

(11) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(12) "PLAN" MEANS A HEALTH MAINTENANCE ORGANIZATION OPERATED BY AN INSURER OR HEALTH SERVICE CORPORATION AS AN INTEGRAL PART OF THE CORPORATION AND NOT AS A SUBSIDIARY.

~~(12)~~(13) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of his practice or other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(13)~~(14) "Uncovered expenditures" mean the costs of

health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent.

NEW SECTION. Section 3. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with [sections 1 through 29]. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first obtains from the secretary of state a certificate of authority to transact business in this state as a foreign corporation under 35-1-1001.

(2) Each health maintenance organization operating in this state as of [the effective date of this act] shall submit an application for a certificate of authority under subsection (3) within 30 days ~~of-[the-effective-date-of-this act]~~ AFTER THE EFFECTIVE DATE OF RULES ADOPTED BY THE COMMISSIONER AND THE DEPARTMENT OF HEALTH AS PROVIDED IN [SECTION 20]. Each such applicant may continue to operate in this state until the commissioner acts upon the application. If an application is denied under [section 4], the applicant

must be treated as a health maintenance organization whose certificate of authority has been revoked.

(3) Each application of a health maintenance organization, whether separately licensed or not, for a certificate of authority must:

(a) be verified by an officer or authorized representative of the applicant;

(b) be in a form prescribed by the commissioner;

(c) contain:

(i) the applicant's name;

(ii) the location of the applicant's home office or principal office in the United States (if a foreign person);

(iii) the date of organization or incorporation;

(iv) the form of organization (including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors);

(v) the state or country of domicile; and

(vi) any additional information the commissioner may reasonably require; and

(d) set forth the following information or be accompanied by the following documents, as applicable:

(i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership

agreement, trust agreement, or other applicable documents, and all amendments thereto, certified by the public officer with whom the originals were filed in the state or country of domicile;

(ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the applicant's internal affairs, certified by its secretary or other officer having custody thereof;

(iii) a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation; and the partners or members in the case of a partnership or association;

(iv) a copy of any contract made or to be made between:

(A) any provider and the applicant; or

(B) any person listed in subsection (3)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

(v) the extent to which any of the following will be included in provider contracts and the form of any provisions that:

(A) limit a provider's ability to seek reimbursement

for basic health care services or health care services from an enrollee;

(B) permit or require a provider to assume a financial risk in the health maintenance organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

(C) govern amending or terminating an agreement with a provider;

(vi) a financial statement showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of [sections 1 through 29].

(vii) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other source of funding;

~~(viii) a summary of feasibility studies or marketing surveys that support the financial and enrollment~~

~~projections--for-the-plan;-including-the-potential-number-of enrollees-in-the-operating-territory;-the--projected--number of--enrollees--for--the--first--5--years;--the--underwriting standards-to-be-applied;-and-the--method--of--marketing--the organization;~~

~~(ix)~~(VIII) a power of attorney executed by the applicant, on a form prescribed by the commissioner, appointing the commissioner, his successors in office, and his authorized deputies as the applicant's attorney to receive service of legal process issued against it in this state;

~~(x)~~(IX) a statement reasonably describing the geographic service area or areas to be served by county, including:

(A) a chart showing the number of primary and specialty care providers with locations and service areas by county;

(B) the method of handling emergency care, with the location of each emergency care facility; and

(C) the method of handling out-of-area services;

~~(xi)~~(X) a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

~~(xii)~~(XI) a description of the complaint procedures to be used as required under [section 11];

~~(xiii)~~(XII) a description of the procedures and programs to be implemented to meet the quality of health care requirements in [section 4];

~~(xiv)~~(XIII) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under [section 6];

~~(xv)~~(XIV) a summary of the way in which administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed for approval with the commissioner in accordance with the filing provisions of [section 8(7)]. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

(C) the method of payment, including any provisions for the administrator to participate in the profits or losses of the plan;

(D) the duration of the contract; and

(E) any provisions for modifying, terminating, or renewing the contract.

~~(xvi) a summary of current and projected enrollment, income from premiums by type of payer, other income, administrative and other costs, the projected break-even point (including the method of funding the accumulated losses until the break-even point is reached), and the assumptions made in developing projected operating results;~~

~~(xvii)~~(XV) a summary of all financial guaranties by providers, sponsors, affiliates, or parents within a holding company system or any other guaranties that are intended to ensure the financial success of the plan, including hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

~~(xviii)~~(XVI) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

~~(xix)~~(XVII) evidence that it can meet the requirement of [section 13(10)]; and

~~(xx)~~(XVIII) any other information that the commissioner may reasonably require to make the determinations required in [section 4].

(4) Each health maintenance organization shall file each substantial change, alteration, or amendment to the

information submitted under subsection (3) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may, AFTER NOTICE AND HEARING, disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may make reasonable rules exempting from the filing requirements of this subsection those items he considers unnecessary.

(5) An applicant or a health maintenance organization holding a certificate of authority shall file with the commissioner all contracts of reinsurance and any modifications thereto. An agreement between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A reinsurance agreement must remain in full force and effect for at least 90 days following written notice of cancellation by either party by certified mail to the commissioner.

(6) Each health maintenance organization shall maintain, at its administrative office, and make available to the commissioner upon request executed copies of all provider contracts.

NEW SECTION. Section 4. Issuance of certificate of authority. (1) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall transmit copies of the application and accompanying documents to the department of health. The department of health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished, has:

(a) demonstrated the willingness and potential ability to assure that it will provide health care services in a manner assuring availability and accessibility of adequate personnel and facilities and enhancing availability, accessibility, and continuity of service;

(b) arrangements, established in accordance with the rules made by the department of health, for an ongoing quality assurance program concerning health care ~~processes and outcomes~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY OF SERVICE; and

(c) a procedure, established in accordance with rules of the department of health, to develop, compile, evaluate, and ~~report~~ statistics relating to the cost of its ~~operations~~, the pattern of utilization of its services, the availability and accessibility of its services, and any other matters as may be reasonably required by the department of health.

(2) Within ~~90~~ 60 days of receipt of the application from a health maintenance organization for issuance of a certificate of authority, the department of health shall certify to the commissioner that the proposed health maintenance organization meets the requirements of subsection (1) or shall, AFTER NOTICE AND HEARING, notify the commissioner that the health maintenance organization does not meet those requirements and specify in what respects it is deficient. The director may extend by not more than an additional 30 days the period within which he may certify to the commissioner that the proposed health maintenance organization meets or does not meet the requirements of subsection (1) by giving notice of the extension to the commissioner and the health maintenance organization before the expiration of the initial ~~90-day~~ 60-DAY period.

(3) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to [section 3] within 180 days of receipt of the certification from the department of health. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in [section 22] if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent~~, trustworthy, and of good~~

reputation AND TRUSTWORTHY.

(b) The department of health certifies, in accordance with subsection (2), that the health maintenance organization's proposed plan of operation meets the requirements of subsection (1).

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

(d) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may in his discretion consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with [section 13]; and

(vi) any additional information as the commissioner may reasonably require.

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to [section 6].

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to [section 3] or by independent investigation, ~~is contrary to the public interest~~ VIOLATES ANY PROVISION OF [SECTIONS 1 THROUGH 29] OR RULES ADOPTED BY THE COMMISSIONER OR THE DEPARTMENT OF HEALTH.

(g) Any deficiencies identified by the department of health have been corrected.

(4) The commissioner may in his discretion deny a certificate of authority only if he complies with the requirements of [section 21].

NEW SECTION. Section 5. Powers of health maintenance organizations. (1) The powers of a health maintenance organization include but are not limited to the following:

(a) the purchase, lease, construction, renovation, operation, or maintenance of a hospital, a medical facility,

or both, its ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(b) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation under its control for the purpose of acquiring or constructing a medical facility or hospital or in furtherance of a program providing health care services to enrollees;

(c) the furnishing of health care services through a provider who is under contract with or employed by the health maintenance organization;

(d) the contracting with a person for the performance on its behalf of certain functions, such as marketing, enrollment, and administration;

(e) the contracting with an insurer authorized to transact insurance in this state, or with a health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization; and

(f) the offering of other health care services in addition to basic health care services.

(2) A health maintenance organization shall file

notice, with adequate supporting information, with the commissioner before exercising a power granted in subsection (1)(a), (1)(b), or (1)(d). The commissioner may disapprove the exercise of a power only if, in his opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. The commissioner may make reasonable rules exempting from the filing requirement of this subsection those activities having a de minimis effect. The exercise of authority granted in subsections (1)(a), (1)(b), and (1)(d) is subject to disapproval by the commissioner. The commissioner may exempt certain contracts from the filing requirement whenever exercise of the authority granted in this section would have little or no effect on the health maintenance organization's financial condition and ability to meet obligations.

(3) Nothing in this section exempts the activities of a health maintenance organization from any applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 6. Governing body. (1) The governing body of a health maintenance organization may include providers or other individuals, or both.

(2) The governing body shall establish a mechanism to give the enrollees an opportunity to participate in matters

of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

NEW SECTION. Section 7. Fiduciary responsibilities. (1) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in the manner of a fiduciary to the health maintenance organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner. Each bond must be written with at least a 1-year discovery period and, if written with less than a 3-year discovery period, must contain a provision that a cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, may not take effect prior to the expiration of 90 days after written notice of the cancellation or termination has been filed with the commissioner unless the commissioner approves an earlier cancellation or termination date.

NEW SECTION. Section 8. Evidence of coverage and charges for health care services. (1) Every enrollee

residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is unjust, unfair, inequitable, misleading, or deceptive; that encourages misrepresentation; or that is untrue, misleading, or deceptive as defined in [section 14(1)]. The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment, which is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that

must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or his dependents;

(f) a provision ~~offering~~ REQUIRING medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol

or drugs in accordance with the limits provided in 33-22-703;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, his dependents, or family members continuing coverage on the enrollee, his dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, his dependents, or family members covered under the evidence of coverage ceases because of termination of employment or of his membership in the class or classes eligible for coverage under the policy or because his employer discontinues his business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting

condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or his dependents from and after the moment of birth.

(c) If a health maintenance organization requires

payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee must not be individually determined based on the status of his health. However, the charges may not be excessive, inadequate, or unfairly discriminatory and cannot be amended more often than once in a 12-month period unless a more frequent amendment is actuarially justified and necessary to preserve the financial solvency of the health maintenance organization. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the charges, based on

reasonable assumptions, must accompany the filing, along with adequate supporting information.

(7) The commissioner shall, within a reasonable period, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form or use a schedule of charges before the commissioner approves the form or the health maintenance organization files the schedule of charges. If the commissioner disapproves the filing, he shall notify the filer. In the notice, the commissioner shall specify the reasons for his disapproval. The commissioner shall grant a hearing within 30 days after he receives a written request by the filer.

(8) The commissioner may in his discretion require a health maintenance organization to submit any information he considers necessary in determining whether to approve or disapprove a filing made pursuant to this section.

NEW SECTION. Section 9. Annual statement -- revocation for failure to file -- penalty for perjury. (1) Each UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN, EACH authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and

content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may in his discretion waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in [section 22]. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in [section 22], or may in his discretion suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may, AFTER NOTICE AND HEARING, impose a fine not to exceed $5,000 per violation upon a director, officer, partner, member, agent, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement which is false.

(4) The commissioner may require such reports as he considers reasonably necessary and appropriate to enable him to carry out his duties under [sections 1 through 29], INCLUDING BUT NOT LIMITED TO A STATEMENT OF OPERATIONS, TRANSACTIONS, AND AFFAIRS OF A HEALTH MAINTENANCE

ORGANIZATION OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN.

NEW SECTION. Section 10. Information to enrollees. Each authorized health maintenance organization shall ~~promptly~~ provide to its enrollees ~~notice~~ 30 DAYS' ADVANCE NOTICE IN WRITING of any material change in the operation of the health maintenance organization that will affect them directly.

NEW SECTION. Section 11. Complaint system. (1) (a) Each authorized health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures to resolve written complaints initiated by enrollees. A health maintenance organization may not use a complaint system:

(i) before the commissioner approves it; and

(ii) unless the health maintenance organization describes it in each evidence of coverage issued or delivered to an enrollee in this state.

(b) Each time the health maintenance organization denies a claim or initiates disenrollment, cancellation, or nonrenewal, it shall notify the affected enrollee of the right to file a complaint and the procedure for filing a complaint.

(c) Each health maintenance organization shall acknowledge a complaint within 10 days of receiving it.

(d) Each health maintenance organization shall retain records of all complaints for 3 years and shall develop a summary for each year that must include:

(i) a description of the procedures of the complaint system;

(ii) the total number of complaints handled through the complaint system, a compilation of causes underlying the complaints filed, the date on which each complaint was filed, the date on which each complaint was resolved, the disposition of each complaint filed, the time it took to process each complaint, and a summary of each administrative change made because of a complaint; and

(iii) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that were settled during the year by the health maintenance organization.

(e) The health maintenance organization shall annually on or before March 1 file with the commissioner the summary described in subsection (1)(d) for the preceding year.

(2) The commissioner shall hold in confidence the information provided by the health maintenance organization pursuant to subsection (1)(d)(iii).

(3) The commissioner may examine a complaint system.

NEW SECTION. Section 12. Investment regulations. A domestic health maintenance organization may invest its

funds only as prescribed in ~~rules--adopted--by--the commissioner~~ TITLE 33, CHAPTER 2, PART 8.

NEW SECTION. Section 13. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation must be the greater of:

(a) 5% of its estimated expenditures for health care services for its first year of operation;

(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or

(c) $100,000.

(3) At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on [the effective date of this act] shall make a deposit equal to the greater of:

(a) 1% of the preceding 12 months' uncovered expenditures; or

(b) $100,000 on the first day of the fiscal year beginning 6 months or more after [the effective date of this act]. In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably reflect the preceding year's operating experience and delivery arrangements.

(5) The commissioner may in his discretion waive any of the deposit requirements set forth in subsections (1) through (4) whenever he is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year;

(b) the health maintenance organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth not including land, buildings, and equipment of at least $1 million or achieves a net worth including organization-related land, buildings, and equipment of at least $5 million the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth not including land, buildings, and equipment of at least $1 million or that has been in operation for at least 10 years and has a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of such

health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit

$100,000 for each $250,000 of reduction in net worth, except that its total deposit may not be required to exceed the maximum required under this section.

(9) ~~Each~~ UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN, EACH health maintenance organization shall have a minimum capital of at least $200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

(a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

(b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical underwriting or preexisting limitation requirements.

NEW SECTION. Section 14. Prohibited practices. (1) A health maintenance organization, or representative thereof, may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of [sections 1 through 29]:

~~(a) a statement or item of information is considered~~

~~to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee of, or person considering enrollment in, a health maintenance organization;~~

~~(b)~~(A) a statement or item of information is considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, a reasonable person, not possessing special knowledge regarding health care coverage, may reasonably understand the statement or item of information as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

~~(c)~~(B) an evidence of coverage is considered to be deceptive if, when taken as a whole and with consideration given to typography, format, and language, it can cause a reasonable person, not possessing special knowledge regarding health maintenance organizations, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage

does not regularly make available to enrollees covered under the evidence of coverage.

(2) Title 33, chapter 18, applies to health maintenance organizations and evidences of coverage issued by a health maintenance organization, except to the extent that the commissioner determines that the nature of health maintenance organizations and evidences of coverage render the chapter clearly inappropriate.

(3) A health maintenance organization shall clearly disclose in the evidence of coverage the circumstances under which it may disenroll, cancel, or refuse to renew an enrollee. A health maintenance organization may only disenroll, cancel, or refuse to renew an enrollee if the enrollee:

(a) has failed to pay required premiums by the end of the grace period;

(b) has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees of the health maintenance organization;

(c) has allowed a nonenrollee to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;

(d) has moved outside of the geographical service area of the health maintenance organization; or

(E) HAS VIOLATED RULES OF THE HEALTH MAINTENANCE ORGANIZATION STATED IN THE EVIDENCE OF COVERAGE;

(F) HAS VIOLATED RULES ADOPTED BY THE COMMISSIONER FOR ENROLLMENT IN A HEALTH MAINTENANCE ORGANIZATION; OR

~~(e)~~(G) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that he may file a grievance on this matter.

(4) A health maintenance organization may not disenroll an enrollee under subsection (3) for reasons related to the physical or mental condition of the enrollee or for any of the following reasons:

(a) failure of the enrollee to follow a prescribed course of treatment; or

(b) administrative actions, such as failure to keep an appointment.

(5) (a) A health maintenance organization that disenrolls a group certificate holder for any reason ~~except failure to pay required premiums~~ NOT LISTED IN SUBSECTION

(3) OR PROVIDED IN RULES ADOPTED BY THE COMMISSIONER shall make arrangements to provide similar alternate insurance coverage to enrollees. The insurance coverage must be continued until the disenrolled group certificate holder finds its own coverage or a period of ~~36~~ 12 months elapses, whichever comes first. The premium on the individual coverage must be at the then-customary rate applicable to the individual coverage offered by the insurer, health service corporation, or health maintenance organization that provides the alternate insurance coverage.

(b) If a health maintenance organization disenrolls an enrollee covered on an individual basis for any reason ~~except failure to pay required premiums~~ NOT LISTED IN SUBSECTION (3) OR PROVIDED IN RULES ADOPTED BY THE COMMISSIONER, coverage must be continued until the anniversary date of the policy or for 1 year, whichever is earlier. A health maintenance organization that disenrolls an individual enrollee for failure to pay a required premium or for fraudulent statements on the enrollment form need not provide alternate insurance coverage to that enrollee.

(6) A health maintenance organization may not refer to itself as an insurer unless licensed as an insurer or use a name deceptively similar to the name or description of an insurer authorized to transact insurance in this state.

(7) A person may not refer to itself as a health

maintenance organization or HMO unless it holds a valid certificate of authority issued by the commissioner.

NEW SECTION. Section 15. Agent license required -- application, issuance, renewal, fees -- penalty. (1) No individual, partnership, or corporation may act as or hold himself out to be an agent of a health maintenance organization unless he is:

(a) licensed as a disability insurance agent by the commissioner pursuant to chapter 17, parts 1, 2, and 4 of this title; and

(b) appointed or authorized by the health maintenance organization to solicit health care service agreements on its behalf.

(2) Application, appointment and qualification for a health maintenance organization agent license, fees applicable to and the issuance of a health maintenance organization agent license, and renewal of a health maintenance organization agent license must be in accordance with the provisions of chapter 17 that apply to a disability insurance agent.

(3) An individual, partnership, or corporation who holds a disability insurance agent license on [the effective date of this act] need not requalify by an examination to be licensed as a health maintenance organization agent.

(4) The commissioner may, in accordance with 33-1-313,

33-1-317, 33-17-411, and chapter 17, part 10, suspend, revoke, refuse to issue or renew a health maintenance organization agent license, or impose a fine upon the licensee.

NEW SECTION. Section 16. Powers of insurers and health service corporations. (1) An insurer authorized to transact insurance in this state or a health service corporation authorized to do business in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of [sections 1 through 29]. Notwithstanding any other law which may be inconsistent with this section, two or more insurers, health service corporations, or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance is considered to include the provision of health care services by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any insurance or health service corporation laws, an insurer or a health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance organization and to provide coverage if the health maintenance organization fails to meet its obligations.

(3) The enrollees of a health maintenance organization constitute a permissible group under this title. The insurer or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers under the contracts described in subsection (2).

(4) Nothing in this section exempts a health maintenance organization that provides health care services from complying with the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 17. Examination. (1) The commissioner may examine the affairs of a health maintenance organization and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary to protect the interests of the people of this state. The commissioner shall make such an examination at least once every 3 years.

(2) The department of health may examine the ~~quality~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY of the health care services provided by any health maintenance organization and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary to protect the interests of the people of this state. The department of health shall make such an examination at least once every 3

years.

(3) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner and the department of health may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.

(4) (a) (i) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or adopted by the commissioner. The commissioner may present such an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any such examination.

(ii) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (4)(a)(i), the commissioner shall pay them out of the funds

of the commissioner in the same manner as other disbursements of such funds. The amount so paid must be a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund.

(b) The expenses of examination conducted by the director under this section must be assessed against the health maintenance organization and remitted to the director. Such remitted expenses are statutorily appropriated to the department of health as provided in 17-7-502.

(5) In lieu of an examination, the commissioner or the director may accept the report of an examination made by the commissioner or the director of another state.

NEW SECTION. Section 18. Suspension or revocation of certificate of authority. (1) The commissioner may in his discretion suspend or revoke any certificate of authority issued to a health maintenance organization under [sections 1 through 29] if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under [section 3], unless amendments to such

submissions have been filed with and approved by the commissioner.

(b) The health maintenance organization issues evidences of coverage or uses a schedule of charges for health care services that do not comply with the requirements of [section 8].

(c) The health maintenance organization does not provide or arrange for basic health care services.

(d) The director, AFTER NOTICE AND HEARING, certifies to the commissioner that:

(i) the health maintenance organization does not meet the requirements of [section 4(1)]; or

(ii) the health maintenance organization is unable to fulfill its obligations to furnish health care services.

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under [section 6].

(g) The health maintenance organization has failed to implement the complaint system required by [section 11] to resolve valid complaints in a reasonable manner.

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(j) The health maintenance organization has otherwise failed to substantially comply with [sections 1 through 29].

(2) The commissioner may in his discretion suspend or revoke a certificate of authority only if he complies with the requirements of [section 21].

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of such suspension, enroll any additional enrollees except newborn infants or other newly acquired dependents of existing enrollees and may not engage in any advertising or solicitation.

(4) If the commissioner revokes the certificate of authority of a health maintenance organization, the health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may not transact further business except as may be essential to the orderly conclusion of its affairs. It may not engage in further advertising or

solicitation following the effective date of the order of revocation. The commissioner may by written order permit further operation of the health maintenance organization if he finds further operation to be in the best interest of enrollees to the extent that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

NEW SECTION. Section 19. Supervision, rehabilitation, or liquidation of a health maintenance organization. (1) The supervision, rehabilitation, or liquidation of a health maintenance organization is considered to be the supervision, rehabilitation, or liquidation of an insurer and must be conducted under the supervision of the commissioner pursuant to chapter 2, part 13. The commissioner may apply for an order directing him to supervise, rehabilitate, or liquidate a health maintenance organization upon any one or more grounds set out in 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as a claim by an enrollee

if the provider of services agrees not to assert the claim against any enrollee of the health maintenance organization.

NEW SECTION. Section 20. Rules. (1) The commissioner may, after notice and hearing, make reasonable rules necessary to effectuate [sections 1 through 29].

(2) The department of health may make reasonable rules necessary to effectuate [sections 1 through 29].

NEW SECTION. Section 21. Administrative procedures. (1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist or that grounds for the suspension or revocation of a certificate of authority exist, he shall give written notice to the health maintenance organization and the department of health specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days after the notice for a hearing on the matter.

(2) The director or his designated representative may attend the hearing and may participate in the proceeding. The recommendations and findings of the director with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority must be conclusive and binding upon the commissioner. After the hearing, or upon the failure of the

health maintenance organization to appear at the hearing, the commissioner shall make written findings and act as he considers advisable. The commissioner shall mail the written findings to the health maintenance organization and submit a copy to the director. The action of the commissioner and the recommendations and findings of the director are subject to review by the district court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

(3) ~~The Montana Administrative Procedure Act, Title 2, chapter 4, applies to proceedings under this section to the extent it is not in conflict with this section.~~ WHERE NOTICE AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE COMMISSIONER UNDER [SECTIONS 1 THROUGH 29], THE REQUIREMENTS OF 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, APPLY, EXCEPT THAT THE FORMAL RULES OF PLEADING AND EVIDENCE MUST BE OBSERVED. TO THE EXTENT THAT 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, DO NOT ADDRESS THE NOTICE AND HEARING REQUIREMENTS OF [SECTIONS 1 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7, APPLY.

(4) WHERE NOTICE AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE DIRECTOR UNDER [SECTIONS 1 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7,

APPLY.

NEW SECTION. Section 22. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

(a) for filing an application for a certificate of authority or amendment thereto, $300;

(b) for filing an amendment to the organization documents that requires approval, $25;

(c) for filing each annual statement, $25.

(2) All fees and miscellaneous charges, except fines or penalties or those amounts received pursuant to [sections 9(3) and 23], collected by the commissioner pursuant to [sections 1 through 29] and the rules adopted thereunder must be deposited in the insurance regulatory trust account pursuant to 17-2-121 through 17-2-123.

(3) The director may assess fees necessary and adequate to cover the expenses of the director's functions~~, other than examinations,~~ under this chapter. ~~Such fees are statutorily appropriated to the department of health as provided in 17-7-502.~~ THESE FEES MUST BE DEPOSITED IN THE GENERAL FUND.

NEW SECTION. Section 23. Penalties and enforcement. (1) The commissioner may, in addition to suspension or revocation of a certificate of authority under [section 18], AFTER NOTICE AND HEARING, impose an administrative penalty

in an amount not less than $500 or more than $10,000 if he gives reasonable notice in writing of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation. ~~The commissioner may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.~~

(2) ~~(a)~~ If the commissioner or the director has cause to believe that a violation of [sections 1 through 29] has occurred or is threatened, the commissioner or the director may:

~~(i)~~(A) give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation;

~~(ii)~~(B) arrange a conference with the alleged violators or their authorized representatives to attempt to ascertain the facts relating to the suspected violation; and

~~(iii)~~(C) if it appears that a violation has occurred or is threatened, arrive at an adequate and effective means of correcting or preventing the violation.

~~(b) Proceedings under this subsection are not governed by any formal procedural requirements and may be conducted in a manner the commissioner or the director considers appropriate under the circumstances. However, unless~~

~~consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of [section 21] or this section are satisfied.~~

(3) (a) The commissioner may issue an order directing a health maintenance organization or its representative to cease and desist from engaging in an act or practice in violation of [sections 1 through 29].

(b) Within 15 days after service of the cease and desist order, the respondent may request a hearing to determine whether acts or practices in violation of [sections 1 through 29] have occurred. The hearing must be conducted pursuant to Title 2, chapter 4, part 6, and judicial review must be available as provided by Title 2, chapter 4, part 7.

(4) If a health maintenance organization violates a provision of [sections 1 through 29] and the commissioner elects not to issue a cease and desist order or if the respondent does not comply with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lewis and Clark County.

NEW SECTION. Section 24. Statutory construction and relationship to other laws. (1) Except as otherwise provided in [sections 1 through 29], the insurance or health service

corporation laws do not apply to ~~any~~ health maintenance organization authorized to transact business under [sections 1 through 29]. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to [sections 1 through 29].

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under [sections 1 through 29] may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of [sections 1 through 29] do not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 25. Filings and reports as public documents. All applications, filings, and reports required under [sections 1 through 29], except those that contain trade secrets or privileged or confidential

commercial or financial information (other than an annual financial statement that the commissioner may require under [section 9]), are public documents.

NEW SECTION. Section 26. Confidentiality of medical information. (1) Any data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant obtained from the enrollee, applicant, or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except:

(a) to the extent that it may be necessary to carry out the purposes of [sections 1 through 29];

(b) upon the express consent of the enrollee or applicant;

(c) pursuant to statute or court order for the production of evidence or the discovery thereof; or

(d) in the event of claim or litigation between the enrollee or applicant and the health maintenance organization wherein the data or information is pertinent.

(2) A health maintenance organization is entitled to claim the same statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

NEW SECTION. Section 27. Authority of director to contract. The director in carrying out his obligations under [sections 4(1), 17(2), and 18(1)] may contract with

qualified persons to make recommendations concerning the determinations he is required to make. The contractors' recommendations may be accepted OR REJECTED in full or in part by the director.

NEW SECTION. Section 28. Acquisition, control, or merger of a health maintenance organization. (1) Except as provided in 33-2-1106 and subsection (2), no person may tender for, request, or invite tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization.

(2) No person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the acquiring person has filed with the commissioner and has sent to the health maintenance organization information required by 33-2-1104(2) and the commissioner has approved the offer, request, invitation, agreement, or acquisition pursuant to

33-2-1105.

NEW SECTION. Section 29. Dual choice. ~~(1) Each public or private employer in this state that employs not less than 25 employees and offers its employees a health benefit plan and each employee benefit fund in this state that offers its members any form of disability insurance benefit shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority that provides health care services in the geographic areas in which a substantial number of the employees or members reside. If there is a prevailing collective bargaining agreement, the selection of the health maintenance organization to be made available to the employees must be made pursuant to the agreement.~~

~~(2)~~ An employer in this state THAT OFFERS ITS EMPLOYEES THE OPTION TO ENROLL IN A HEALTH MAINTENANCE ORGANIZATION AND AN EMPLOYEE BENEFIT FUND IN THIS STATE THAT OFFERS ITS MEMBERS THE OPTION TO ENROLL IN A HEALTH MAINTENANCE ORGANIZATION may not be required to pay more for health benefits ~~as a result of the application of this section~~ PROVIDED BY THE HEALTH MAINTENANCE ORGANIZATION than it would otherwise be required to provide by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, if the

employer or benefits fund pays to the health maintenance organization chosen by each employee or member an amount equal to the lesser of:

~~(a)~~(1) the amount paid on behalf of its other employees or members of health benefits; or

~~(b)~~(2) the health maintenance organization's charge for coverage approved by the commissioner pursuant to [section 8].

~~Section 30. Section 33-22-111, MCA, is amended to read:~~

~~"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All~~ Except as provided in [sections 1 through 29], all ~~policies of disability insurance, including individual, group, and blanket policies, and all policies insuring the payment of compensation under the Workers' Compensation Act shall provide the insured shall have full freedom of choice in the selection of any duly licensed physician, dentist, osteopath, chiropractor, optometrist, chiropodist, psychologist, licensed social worker, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of his practice. Whenever such policies insure against the expense of drugs, the insured shall have full freedom of choice in the selection of any duly licensed and registered pharmacist.~~

An insurer shall offer, at additional cost to the insured, the option of disability and health insurance coverage for services performed by a licensed professional counselor.

(2) Nothing in this section shall be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1), nor shall this section be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

Section 31. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;

(b) 2-17-105;

(c) 2-18-812;

(d) 10-3-203;

(e) 10-3-312;

(f) 10-3-314;

(g) 10-4-301;

(h) 13-37-304;

(i) 15-31-702;

(j) 15-36-112;

(k) 15-70-101;

(l) 16-1-404;

(m) 16-1-410;

(n) 16-1-411;

(o) 17-3-212;

(p) 17-5-404;

(q) 17-5-424;

(r) 17-5-804;

(s) 19-8-504;

(t) 19-9-702;

(u) 19-9-1007;

(v) 19-10-205;

(w) 19-10-305;

(x) 19-10-506;

(y) 19-11-512;

~~(z)--19-11-513,~~

~~(aa)-19-11-606,~~

~~(bb)-19-12-301,~~

~~(cc)-19-13-604,~~

~~(dd)-20-6-406,~~

~~(ee)-20-8-111,~~

~~(ff)-23-5-612,~~

~~(gg)-(section-17),~~

~~(hh)-(section-22),~~

~~(gg)((ii))-37-51-501,~~

~~(hh)((jj))-53-24-206,~~

~~(ii)((kk))-75-1-1101,~~

~~(jj)((ll))-75-7-305,~~

~~(kk)((mm))-80-2-103,~~

~~(ll)((nn))-80-2-228,~~

~~(mm)((oo))-90-3-301,~~

~~(nn)((pp))-90-3-302,~~

~~(oo)((qq))-90-15-103,-and~~

~~(pp)((rr))-Sec.-13,-HB-861,-L.-1985,~~

~~(4)--There-is-a--statutory--appropriation--to--pay--the principal,-interest,-premiums,-and-costs-of-issuing,-paying, and-securing-all-bonds,-notes,-or-other-obligations,-as-due, that-have-been-authorized-and-issued-pursuant-to-the-laws-of Montana.---Agencies---that---have--entered--into--agreements authorized--by--the--laws--of--Montana--to--pay--the---state~~

~~treasurer,--for--deposit-in-accordance-with-17-2-101-through 17-2-107,-as-determined-by-the-state--treasurer,--an--amount sufficient--to--pay-the-principal-and-interest-as-due-on-the bonds-or-notes-have-statutory--appropriation--authority--for such-payments."~~

SECTION 30. SECTION 33-1-102, MCA, IS AMENDED TO READ:

"33-1-102. Compliance required -- exceptions -- health service corporations. (1) No person shall transact a business of insurance in Montana or relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) No provision of this code shall apply with respect to:

(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code shall not apply to health service corporations to the extent that the existence and operations of such corporations are authorized by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and

operations of such organizations are authorized by [sections 1 through 29]."

SECTION 31. SECTION 33-1-704, MCA, IS AMENDED TO READ:

"33-1-704. Hearing procedure. (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) ~~Formal~~ Except as provided in [section 21], rules of pleading or evidence need not be observed at any hearing.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of

such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

NEW SECTION. Section 32. Codification instruction. Sections 1 through 29 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through 29.

NEW SECTION. Section 33. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 34. Effective date -- applicability. ~~This act is~~ SECTION 20 AND THIS SECTION ARE effective on passage and approval ~~and~~. THIS ACT applies to health maintenance organizations formed before or after the effective date of this act.

-End-

SENATE BILL NO. 353

INTRODUCED BY MEYER, LORY, BENGTSON, MILLER, MCLANE, SANDS

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE FORMATION AND OPERATION OF HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS ~~17-7-502--AND--33-22-111~~ 33-1-102 AND 33-1-704, MCA; AND PROVIDING AN ~~IMMEDIATE~~ EFFECTIVE DATE AND AN APPLICABILITY PROVISION."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Short title. This act may be cited as the "Montana Health Maintenance Organization Act".

NEW SECTION. Section 2. Definitions. As used in [sections 1 through 29], unless the context requires otherwise, the following definitions apply:

(1) "Agent" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(2) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

THERE ARE NO CHANGES IN SB 353 AND DUE TO LENGTH WILL NOT BE RE-RUN. PLEASE REFER TO SECOND READING (YELLOW) COPY FOR COMPLETE TEXT.

THIRD READING

SB-353

BUSINESS & LABOR COMMITTEE

50TH LEGISLATIVE SESSION

1987

Committee Members	District
Rep. Les Kitselman, Chairman	95
Rep. Fred Thomas, Vice Chairman	62
Rep. Bob Bachnini	14
Rep. Ray Brandewie	49
Rep. Jan Brown	46
Rep. Ben Cohen	3
Rep. Jerry Driscoll	92
Rep. William Glaserl	98
Rep. Larry Grinde	30
Rep. Stella Jean Hansen	57
Rep. Tom Jones	4
Rep. Lloyd McCormick	38
Rep. Gerald Nisbet	35
Rep. Bob Pavlovich	70
Rep. Bruce Simon	91
Rep. Clyde Smith	5
Rep. Charles Swysgood	73
Rep. Norm Wallin	78

Secretary

Elsie Sebens-Armstrong

Staff

Paul Verdon

Form CS-32
Rev. 1985

STATUS SHEET

50th LEGISLATIVE SESSION

BUSINESS AND LABOR COMMITTEE

SENATE BILL NUMBER	ENTERED COM. DATE	DATE CON-SIDERED	OUT OF COM.	DO PASS DATE	DO NOT PASS DATE	DO PASS AS AMENDED DATE	DO NOT PASS AS AMENDED DATE	BE CON-CURRED IN DATE	BE NOT CON-CURRED IN DATE	BE CON-CURRED IN AMENDED DATE	BE NOT CONCURRED IN AS AMENDED DATE
299	2/24/87	3/13/87	3/13/87					3/13/87			
313	2/24/87	3/13/87	3/13/87							3/13/87	
314	2/24/87	3/13/87	tabled 3/13/87								
315	3/3/87	3/9/87	3/26/87							3/26/87	
318	2/23/87	3/18/87	3/18/87					3/18/87			
319	2/24/87	3/13/87	tabled 3/13/87								
328	3/3/87	3/10/87	3/26/87							3/26/87	
341	3/3/87	3/10/87	3/20/87							3/20/87	
353	3/13/87	3/20/87	3/26/87							3/26/87	
359	3/3/87	3/18/87	3/18/87							3/18/87	
360	3/3/87	3/18/87	3/20/87					3/20/87			
364	3/03/87	3/11/87	3/11/87					3/11/87			
371	3/13/87	3/20/87	3/26/87							3/26/87	
374	2/24/87	3/17/87	3/17/87					3/17/87			

Use a separate sheet for Senate Bills, House Bills, and Resolutions.

MINUTES OF THE MEETING
BUSINESS AND LABOR COMMITTEE
50TH LEGISLATIVE SESSION

March 20, 1987

The meeting of the Business and Labor Committee was called to order by Chairman Les Kitselman on March 20, 1987 at 8:00 a.m. in room 312-F of the state capitol.

ROLL CALL: All members were present.

EXECUTIVE ACTION

ACTION ON SENATE BILL NO. 250

Rep. Thomas moved that Senate Bill No. 250 BE CONCURRED IN. The motion carried unanimously.

Rep. Spaeth will carry the bill in the House.

ACTION ON SENATE BILL NO. 341

Rep. Brandewie moved that Senate Bill No. 341 BE CONCURRED IN.

Rep. Thomas moved the amendments to Senate Bill No. 341. The motion carried unanimously.

Rep. Brandewie moved that Senate Bill No. 341 BE CONCURRED IN AS AMENDED. The motion carried unanimously.

Rep. Simon will sponsor the bill in the House.

ACTION ON SENATE BILL NO. 298

Rep. Hansen moved that Senate Bill No. 298 BE CONCURRED IN.

Rep. Hansen moved the amendments to Senate Bill No. 298. The motion carried with 8 opposed.

Rep. Cohen moved that Senate Bill No. 298 BE TABLED. The motion failed 11 to 7.

Rep. Driscoll moved that Senate Bill 298 BE CONCURRED IN AS AMENDED. The motion carried.

Rep. Bardanouve will sponsor the bill in the House.

ACTION ON SENATE BILL NO. 360

Rep. Glaser moved that Senate Bill No. 360 BE CONCURRED IN. The motion passed unanimously.

PROPONENTS

Pam Langley, representing Montana Agricultural Business Association. Ms. Langley stated they would like a thorough study of the lien laws that exist in Montana.

John Cadby, representing Montana Bankers Association. Mr. Cadby stated they would like to get this problem resolved.

Ronna Alexander, representing Montana Petroleum Marketers. Ms. Alexander stated this is an area that needs to be addressed.

OPPONENTS

None.

QUESTIONS

None.

CLOSING

Rep. Brandewie made no further comments.

EXECUTIVE ACTION

ACTION ON HOUSE JOINT RESOLUTION 46

Rep. Brandewie moved HJR 46 DO PASS. The motion carried with Rep. Grinde opposed.

SENATE BILL 353 - Regulate Health Maintenance Organizations, sponsored by Senator Darryl Meyer, Senate District No. 17, Great Falls. Sen. Meyer stated this bill would regulate the formation and operation of health maintenance organizations. He said because they emphasize prevention of illness and disease, HMO's are promoted as an effective means of health care cost containment. He commented the difference between an HMO and health insurance company is that an HMO actually provides health care services through an assigned physician or provider.

PROPONENTS

Kathy Irigoin, State Auditor's Office, explained the legislation and submitted amendments (exhibit 2), which she explained. Exhibit Nos. 1 and 2.

Bill McDonald, representing an HMO group Health of Western Montana. Mr. McDonald expressed support for the legislation and the amendments presented by the Auditor's office with the exception of number six (6).

Mona Jamison, representing the Rocky Mountain Treatment Center, spoke in support of the legislation and the importance of allowing the consumer to choose what treatment center they want to utilize and pay a comparable fee.

Ann Scott, Rocky Mountain Treatment Center, Great Falls, expressed support for the legislation and the amendments that allow freedom of choice for treatment centers at a comparable fee.

Joan Rebish, representing Montana Mental Health Counselors, stated support for the bill, particularly on page 2 that specifically addresses treatment of mental illness that was added, and the amendments proposed by the State Auditor's Office.

William Evans, representing Montana Chapter of Social Workers, expressed their support for the Auditor's office to establish rules and regulations for HMO providers and the amendments.

Steve Waldron, representing the Mental Health Association, expressed support for the legislation and distributed an amendment and a Business and Health article on the hidden costs of HMOs. Exhibit Nos. 3 and 4.

Pat Callbeck Harper, representing Montana Psychological Association, presented written testimony. Exhibit No. 5.

Mike Murry, representing Chemical Dependency Association. Mr. Murry stated they support the bill and the amendments proposed by Ms. Jamison.

Dennis Duncan, representing Montana Medical Association, presented the Association's position paper on SB 353. Exhibit No. 6.

Joy McGrath, representing Montana Mental Health Association. Ms. McGrath stated they support the bill and the amendments proposed. They feel that the multi-disciplinary utilization boards are important for mental health consumers.

Chuck Butler, Vice President, Blue Cross/Blue Shield. Mr. Butler stated that Blue Cross/Blue Shield is the only organization in the state of Montana that is operating an HMO. He stated that Blue Cross/Blue Shield is in favor of passage of SB 353 which is a result of a two year study. He commented Blue Cross/Blue Shield welcomes the competition from any HMO that can meet the requirements established by this legislation. He suggested that there be some exclusions made for Blue Cross/Blue Shield, other insurers, and federally qualified HMO's that can by current statute or federal law provide HMO programs and are currently regulated. He said their proposed amendments address this. Mr.

Butler submitted proposed amendments and a promotional flier explaining their HMO program. Exhibit Nos. 7 and 8.

OPPONENTS

None.

QUESTIONS

Rep. Wallin asked Mr. Duncan to explain how the cost effectiveness of HMO programs. Mr. Duncan responded that the cost effectiveness is difficult to quantify in terms of dollars and cents. He said the HMO product that is offered is traditionally very competitive cost wise, and that the cost effectiveness of all HMO's are found in the fact that the utilization controls that are utilized in the HMO product is a means of controlling unnecessary hospitalizations, physician services or ancillary services.

Rep. Wallin asked at what point did the HMO organizations become attractive. Mr. Duncan responded that from experiences shown in the industry HMO's become attractive when it can be shown to employers, who are traditionally buying that health care product for their employees, and can have a significant number of physicians that are going to be able to offer the health care services to their employees.

Rep. Wallin asked what was the largest hospital in Montana that has HMO that would be willing to accept patients, for example, from Helena. Chuck Butler responded that HMO Montana have patients and members from Lewis and Clark County that could be treated at any hospital in the state of Montana and their services would be reimbursed.

CLOSING

Sen. Meyer stated that a lot of work had been done attempting to make this a good bill, which would give consumers financially sound HMO program in Montana.

SENATE BILL NO. 371 - Regulate Preferred Provider Arrangements, sponsored by Senator Pat Regan, Senate District No. 47, Billings. Senator Regan stated this bill allows insurers to enter into agreements with health care providers and to issue policies that include incentives for utilizing services rendered by providers with whom the insurer has an agreement, or they may limit reimbursements if they do not use that service. She said under current law there are no provisions for this kind of statute and have always used freedom of choice of practitioner. She commented this bill would not prohibit freedom of choice, but rather would award a person if the preferred provider was used. She added that industry and she agrees with the amendments proposed by the State Auditor's Office.

DAILY ROLL CALL

BEST COPY AVAILABLE

BUSINESS & LABOR COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date MARCH 20, 1987

NAME	PRESENT	ABSENT	EXCUSED
REP. LES KITSELMAN, CHAIRMAN			
REP. FRED THOMAS, VICE-CHAIRMAN			
REP. BOB BACHINI			
REP. RAY BRANDEWIE			
REP. JAN BROWN			
REP. BEN COHEN			
REP. JERRY DRISCOLL			
REP. WILLIAM GLASER			
REP. LARRY GRINDE			
REP. STELLA JEAN HANSEN			
REP. TOM JONES			
REP. LLOYD MCCORMICK			
REP. GERALD NISBET			
REP. BOB PAVLOVICH			
REP. BRUCE SIMON			
REP. CLYDE SMITH			
REP. CHARLES SWYSGOOD			
REP. NORM WALLIN			

CS-30

EXHIBIT 1
DATE 3-20-87
HB SB 353

WRITTEN TESTIMONY OF STATE AUDITOR'S OFFICE
SENATE BILL 353
March 20, 1987

I. Reason for Senate Bill 353

The State Auditor requested Senate Bill 353 because existing law (specifically 33-22-111, MCA--Montana's freedom of choice of practitioners law) precludes health maintenance organizations (HMOs) from operating in Montana unless they are federally qualified or operated by a health service corporation like Blue Cross/Blue Shield. A health service corporation may operate a HMO in Montana because a Montana Attorney General's opinion holds that health service corporations are not insurance companies and therefore are not subject to the Montana Insurance Code (37 Op. Att'y Gen. 151 (1978)). A federally qualified HMO may operate in Montana because the Federal HMO Act (42 U.S.C. 300e (Supp. V. 1975)) preempts state laws like Montana's freedom of choice of practitioner's law (42 U.S.C. 300e-10(a)(1)(A) through (C)). Because of Montana's freedom of choice of practitioners law, no other HMO may operate in Montana. Senate Bill 353, if passed, would permit any HMO that meets its requirements to operate in Montana.

II. Senate Bill 353 Includes Necessary Consumer Protections

Senate Bill 353 includes important consumer protections. For example, Senate Bill 353 meaningfully addresses the financial solvency of an HMO. It requires a HMO to have a minimum capital of at least $200,000 (page 34, line 7). The $200,000 minimum capital required by Senate Bill 353 reflects the $200,000 that the Montana Insurance Code requires disability insurance companies to maintain (33-2-109, MCA). The $200,000 minimum capital required by Senate Bill 353 also takes into consideration that Montana should not require a HMO to have a higher minimum capital requirement than it requires disability insurance companies to maintain. In addition, Senate Bill 353 permits financial examination of an HMO (page 41, lines 11 through 17; and page 42, lines 2 through 9).

In terms of consumer protections related to matters other than financial integrity of the HMO, Senate Bill 353 specifies that each evidence of coverage must contain definitions of key terms used in the evidence of coverage (page 21, lines 13 through line 21); clear disclosure of each provision that limits benefits or access to services (page 21, line 22 through line 14, page 22); clear disclosure of limits on certain benefits (page 21, line 22 through line 14, page 22); clear

disclosure of benefits (page 22, lines 15 through 19); newborn infant coverage (page 22, lines 20 through 22; and page 24, line 10 through line 6, page 25); mandatory coverage for medical treatment of mental illness, alcoholism, and drug addiction (page 22, line 23 through line 2, page 23); conformity with state statutes (page 23, lines 3 through 8); conversion rights (page 23, lines 9 through 13); and clear disclosure of the amount of money an enrollee shall pay the HMO for basic health care services (page 24, lines 3 through 5).

Senate Bill 353 requires a HMO that denies a claim or initiates disenrollment, cancellation, or nonrenewal to notify the affected enrollee of the right to file a complaint with the HMO (page 28, lines 19 through 23). Senate Bill 353 also restricts and requires disclosure of the reasons for which and a HMO may disenroll, cancel, or refuse to renew an enrollee (page 36, line 9 through line 22, page 37).

Senate Bill 353 requires an individual, partnership, or corporation who acts as an agent selling HMO coverage to be licensed as disability insurance agent (page 39, line 4 through line 4, page 40). The states of Washington and Idaho have the same requirement.

III. Senate Bill 353 Incorporates Suggestions of the Department of Health

Senate Bill 353 incorporates suggestions of the department of health, which will regulate and review the availability, accessibility, and continuity of health care in HMOs operating in Montana because the insurance department lacks the expertise to perform those duties (page 13, lines 5 through 25; and page 41, line 18 through line 1, page 42). In addition, Senate Bill 353 includes authority for the director of health to contract with qualified persons to make recommendations concerning the determinations he is required to make (page 53, line 23 through line 4, page 54).

Senate Bill 353 gives the department of health 60 days (with an optional extension of 30 days) to certify a HMO application to the insurance commissioner (page 14, lines 1 and 16). Senate Bill 353 clarifies that the HMO Act does not exempt HMO activities from applicable certificate of need requirements (page 18, lines 17 through 20; page 41, lines 7 through 10; and page 52, lines 18 through 21).

Senate Bill 353 provides the department of health rulemaking authority (page 47, lines 6 through 7). Senate Bill 353 merely permits the director of health to attend and participate in an administrative hearing instituted by the

insurance commissioner (page 47, lines 18 through 19). Senate Bill 353 authorizes the director of health to assess fees necessary and adequate to cover the expenses of his functions, other than examinations (page 49, lines 16 through 21).

IV. Senate Bill 353 Accommodates the Small Insurance Department Staff

Senate Bill 353 requires an applicant for a HMO certificate of authority to provide information that will assist the small insurance department staff in corresponding with the applicant (page 6, lines 9 through 20). It also permits an HMO to file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract to decrease the amount of paper the part-time staff person must spend to review contracts and to accommodate the shortness of storage space in the insurance department (page 7, lines 19 through 21). Senate Bill 353 gives the insurance department 180 days after receipt of the certified application for a HMO certificate of authority from the department of health to issue or deny a certificate of authority (page 14, lines 17 through 20). Under present insurance law, the insurance department is under no time limitation to approve or deny an application for a certificate of authority.

V. Explanation of Amendments

Having considered amendments proposed by various parties interested in Senate Bill 353, the State Auditor's Office offers 14 amendments, including amendments suggested by representatives of mental health providers and Blue Cross/Blue Shield.

Amendment 1 removes language from the statement of intent that no longer is necessary since the Senate amended section 12 so that the commissioner will not adopt HMO investment guidelines by rule. It also removes the suggestion that the commissioner look to regulations adopted by the state of Minnesota in implementing the bill.

Amendment 2 clarifies that the commissioner must approve or disapprove, within 30 days, an exercise of certain powers by a HMO.

Amendment 3 removes undefined language ("unjust, unfair, inequitable, misleading, or deceptive") from the bill.

Amendments 4 and 5 correct the reference to the insurance laws relating to coverage of mental illness, alcoholism, and drug addiction.

Amendment 6 provides that a HMO may not limit an enrollee to a HMO provider for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction.

Amendment 7 clarifies that the commissioner must approve or disapprove a form within 60 days after it is filed.

Amendment 8 clarifies that the commissioner require a HMO to submit only "relevant" information in determining whether to approve or disapprove a form filing.

Amendments 9 and 14 clarify that if House Bill 741 does not pass, an individual, partnership, or corporation enrolling people into a HMO operated by a health service corporation must be licensed as a disability insurance agent.

Amendment 10 removes language from the bill that would have allowed the commissioner to examine the affairs of providers with whom an HMO has contracts, agreements, or other arrangements.

Amendment 11 corrects language in the bill consistent with amendments made in the senate.

Amendments 12 and 13 add an annual fee of $300 for a HMO to continue its certificate of authority.

VI. Conclusion

The Senate Public Health Committee and subcommittee considering Senate Bill 353 devoted considerable time in coming up with the legislation before you today. The bill embodies compromises reached through discussion between all who are affected by it--industry, providers, potential HMO consumers, the Department of Health, and the Insurance Department. A lot of work went into making this a good bill--a bill that all parties can support and that all agree is in the best interests of Montanans. If Senate Bill 353 passes, Montana consumers can expect to find financially sound HMOs that treat them fairly.

EXHIBIT 2
DATE 3-20-87
HB SB 353

PROPOSED AMENDMENTS OF STATE AUDITOR'S OFFICE
SENATE BILL 353
March 20, 1987

1. Statement of intent, page 2, lines 9 through 14.
Strike: lines 9 through 15 in their entirety

2. Page 18, line 3.
Following: "may"
Insert: "within 30 days"

3. Page 20, lines 18 through 19.
Strike: "unjust, unfair, inequitable, misleading, or deceptive; that encourages misrepresentation; or that is"

4. Page 23, line 1.
Following: "limits"
Insert: "and coverage"

5. Page 23, line 2.
Strike: "33-22-703"
Insert: "Title 33, chapter 22, part 7"

6. Page 23.
Following: line 2
Insert: "A health maintenance organization may not limit an enrollee to a health maintenance organization provider for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction"

7. Page 26, lines 3 through 4.
Strike: "a reasonable period"
Insert: "60 days"

8. Page 26, line 15.
Following: "any"
Insert: "relevant"

*9. Page 39, line 8.
Following: "4"
Insert: "[or chapter 30]"

*NOTE: See amendment 14 for coordination instruction.

10. Page 41, lines 13 through 15.
Strike: "and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements"

11. Page 47, lines 21 through 22.
Strike: "quality"
Insert: "availability, accessibility, and continuity"

12. Page 49, line 9.
Strike: "."
Insert: "; and"

13. Page 49.
Following: line 9
Insert: "(d) for annual continuation of certificate of authority, $300.

14. Page 62.
Following: line 13
Insert: "Section 33. Coordination instruction. If House Bill 741 is not passed and approved, the bracketed language in subsection (1)(a) of section 15 of this act is void."

EXHIBIT 3
DATE 3.20.87
SB 353

SB 353 AMENDMENTS
HEALTH MAINTENANCE ORGANIZATION (HMO)

Page 39, line 3,
insert: (8) A health maintenance organization may not knowingly offer direct incentive payments or direct disincentive payment reductions to a physician as an inducement to limit referrals to specialty health care providers.

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EXHIBIT 4
DATE 3-20-07
SB 353

The Hidden Costs of HMOs

BY GWYNNE R. WINSBERG

Without employer specific data, few companies can tell what, if any, savings HMOs produce.

COST MANAGEMENT REPORT

The demand by employers for data, which can be used to make rational judgments in the design and offering of health care benefits, has escalated rapidly in the last three years. Insurance carriers and third party administrators, whose previous concern was paying claims in a timely fashion, kept only the data necessary for the calculation of next year's premiums. Now they increasingly are meeting the new market need for sophisticated data on their clients' use of the health care system.

Employer specific health care utilization data that currently are being generated by a few insurance carriers are not available, however, from the typical health maintenance organization (HMO). Therefore, in the majority of cases, an HMO cannot tell a given employer whether or not employees are utilizing HMO services in a cost-effective manner. The employee usually is satisfied if the out-of-pocket cost for an HMO is no more or only a few dollars more than the traditional indemnity coverage offered by an employer, and the employer is satisfied if the premium is lower or the same as for the traditional plan.

No Savings for Employers

The ratio of HMO premiums to indemnity premiums varies radically across the country and depends less on an employer's utilization experience than on efficiency of HMO management and the need to compete for market share. Thus, while the savings credited to the reported radical reduction in hospital days by HMOs should be more than sufficient to offset theoretical increased utilization of ambulatory services, employers have no means of knowing the magnitude of these savings. Moreover, the employer cannot determine if savings are being used up through excessive ambulatory visits, unusually high costs per patient hospital day, poor HMO management or high returns to investors or physician providers.

Several studies undertaken by the U.S. Department of Health and Human Services during the late 1970s showed considerable evidence that organized systems of health care, such as the community health center, decreased the cost of medical care to the government even for the urban and rural poor populations represented. The costs for these populations, located in Kentucky, Michigan, Minnesota, and California, were significantly reduced by giving the community access to primary care physicians as an alternative to the hospital emergency room. As a result, hospital days per 1,000 average length of stay and hospital admissions radically decreased along with inappropriate visits to the emergency room.

The HMO has also demonstrated by using primary care physicians as gatekeepers that hospitalization days per 1,000 and visits to the emergency room can be reduced drastically. What this should mean to the employer, who pays the insurance bill, is a significant savings in benefit costs. This is only rarely the case.

Some HMOs, in spite of good management and excellent medical outcomes, fail to pass on savings to their subscribers. If the employer is satisfied with an HMO premium $5 or $6 below that of the alternative plans, then no incentive to lower the premium exists. Many well-managed HMOs have become price followers, but the corporate buyer does not have the tools to determine this yet.

Nevertheless, the HMO is an increasingly attractive health care delivery option to employers of all sizes. In those areas of the country where HMO premiums are lower than that of less comprehensive indemnity plans, such as in California and Michigan, the employer at first appears to realize considerable cost savings. And, of course, the larger the employer, the greater the apparent cost savings over the indemnity premium. There is also speculation among corporations that HMOs reduce em-

Gwynne R. Winsberg is president of GRW Associates, Inc. in Chicago.

ployee absences because they focus on prevention and health promotion. At present, however, there is no clear-cut research to validate this assumption.

To determine the nature of the HMO risk, it is necessary to know the characteristics of the enrollees of the individual employer. Data must be kept on all workers as to age, sex, marital status, number of dependents, generally and number under six years of age, job classification and prior health status. In addition, the employer must be able to determine how HMO enrollees differ in these characteristics from other employees enrolled in an indemnity plan or other health care options.

If a study of HMOs could show that they tended to reduce absenteeism among enrollees, then an additional cost savings to the employer could be realized. Short-term absences, unlike the long-term absences covered by disability insurance, require a significant outlay of funds for replacement of the worker, frequently doubling the amount paid for the days of sick leave. These costs should be added to the premiums paid for the health care benefit in order to understand the cost of that benefit. Unfortunately, any savings in workdays, or even in the amount of hospitalization, also can be attributed to better health status of the employees choosing the benefit.

Who Uses HMOs?

General Motors was chosen as the subject for a 1983 study funded by The John A. Hartford Foundation on the effect of employee health plan selection on absenteeism. The study population consisted of over 30,000 blue-collar workers at four separate plant sites of the GM system in Flint, Detroit and Saginaw, Mich., and Rochester, N.Y. Data were obtained from the employer that, in addition to hours of excused absence, included choice of benefit plan, worker age, seniority, marital status, sex, number of dependents, occupational code and several measures of hours worked and hours scheduled.

People who worked less than 1,000 hours in the year were eliminated on the basis that they were not regular full-time employees. The final sample included 5,024 HMO enrollees and 23,618 enrollees in a high option, Blue Cross-Blue Shield plan. No retirees were included in this study.

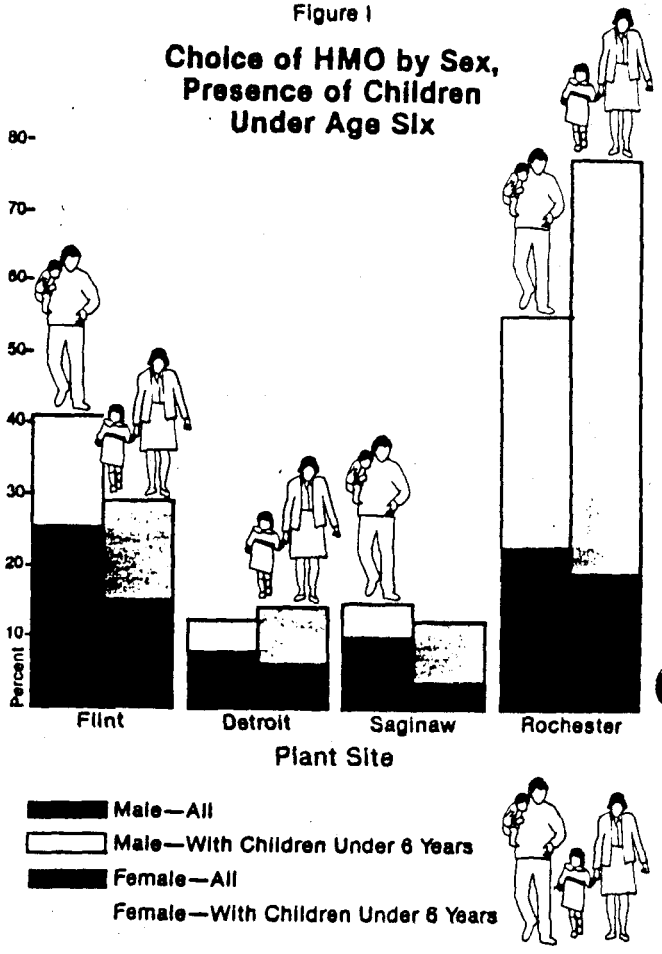
The worksites offered a range of activities from auto assembly to light manufacturing and were chosen on the basis of several criteria: Each had to offer an HMO; the HMO had to have been in existence for more than three years; and it had to have been offered to GM employees for at least two years. The HMOs selected had the highest penetration rates (8.2 percent to 24.5 percent) for GM hourly employees. Both independent practice association (IPA) and group-staff models, as well as private nonprofit and Blue Cross-Blue Shield subsidiary HMOs were represented.

The study was based on data for the 1983 work year. Thus, GM workers tended to be older than expected — an average 40 years of age in all plants — due to the extensive layoffs in the auto industry at that time. Seniority and age were correlated closely. However, workers in Rochester had slightly lower seniority than in the other three sites.

Employees were classified into production workers, nonproduction workers and skilled workers. The HMOs studied encompassed three group-staff models, two of which were subsidiaries of Blue Cross, one in Rochester and the other in Michigan. The fourth HMO was a privately owned, nonprofit IPA.

Figure I

Choice of HMO by Sex, Presence of Children Under Age Six



Source: G.R. Winsberg and J. Vidmar, "Absenteeism and Health Care," (Final Report, The John A. Hartford Foundation: New York City, March 1985).

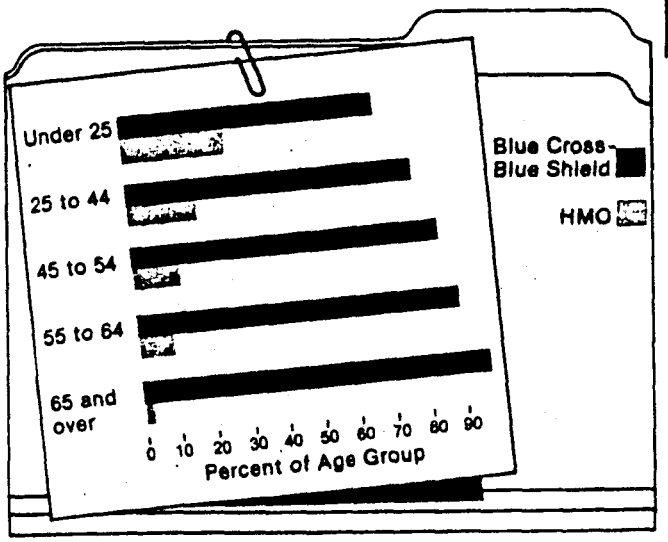
In this study, those GM employees choosing the HMO option tended to be younger than the average age of 40, had more dependents, were more likely to be married and living with a spouse, and to be in a skilled worker category. They also were more likely to be male. In all but a few cases, comparisons between Blue Cross and HMO enrollees were statistically significant regarding those choosing each of the plan options at each of the four sites across the six characteristics presumed to affect health behavior and utilization: age; seniority; number of dependents; marital status; sex and occupational level.

The presence of children under age six, those most likely to have need for the preventive care offered by the HMO, appeared to have a strong influence on worker choice for the HMO option. This effect was particularly strong at Rochester, where males were more than twice as likely to choose an HMO if they had children under age six and women were nearly four times as likely to

do so (see Figure I). Having young children, of course, highly correlates with the age of the worker. A very strong effect of age on choice of health plan was found across all of the plant locations. Sixty-two percent of HMO enrollees were under age 40 compared to 45 percent of Blue Cross beneficiaries. The likelihood of choosing the HMO option decreased markedly with increasing age of the worker, with the greatest likelihood occurring in the age group under 25, where nearly 30 percent of workers chose the HMO option. More than one out of five workers in the 25 to 44 age group chose the HMO, but this percentage dropped off rapidly to about 12 percent in the 45 to 54 age group and to 10 percent in the group between 55 and 65 years of age (see Figure II).

Figure II

Choice of Health Plan by GM Worker Age All Plants



Source: G.R. Winsberg and J. Vidmar, "Absenteeism and Health Care," (Final Report, The John A. Hartford Foundation: New York City, March 1985).

The relationship between choice of health benefit plan and worker skill is striking. At three of the four plants, Flint, Saginaw and Rochester, there was a very strong and statistically significant likelihood of the skilled workers choosing HMOs at a higher rate than workers in the other two categories. Only in Saginaw was the relationship somewhat weaker, although it was in the expected direction.

Over half of the workers in all four plant locations had four or fewer days of absence for all causes. In the year studied, almost 28 percent of the workers had negligible absences or none at all. Conventional wisdom suggests that absences associated with illness and disability would increase with age. However, in this group, high levels of absence decreased with increasing age. Unfortunately, worker absence in order to seek health care for himself, herself or dependents was not distinguishable from absence for reasons such as jury or military duty.

The results of the GM analysis showed a statistically significant difference in absence hours for HMO enrollees, which on the average, was about 10.5 hours fewer per year than for indemnity plan participants. However, the effect of plan choice on absenteeism was considerably less than that of sex differences. Males had considerably lower annual absences than females, accounting for nearly a five-day difference in the regression analysis. Location also was a strong factor, with the Flint site experiencing considerably higher absence rates than either Rochester or Detroit. The higher absence rate at Flint may be attributed to a significantly higher proportion of single males employed at the GM plant. HMO membership among GM employees, however, appeared to be associated with an average day to a day and a half reduction in worker absenteeism annually when compared to Blue Cross enrollees.

Impact on the Work Force

Given the demographic differences between the two types of enrollees in the GM study, the data strongly suggest that these HMOs are enrolling employees who are better health risks. Absenteeism and other indicators of health status, such as the younger age of the HMO enrollees, would indicate an expected lower level of illness and utilization of costly hospital based services. High worker skill level, which can be seen as a proxy for educational level and occupational status, is also positively associated with HMO membership. In general, utilization data suggest that the presence of the more skilled or more educated workers in the HMO would also tend to lower the overall demand for services.

The higher average number of dependents associated with the HMO enrollees indicates a higher overall use of services. However, the population under age six tends to use the less expensive, well child or preventive services, including immunizations and checkups. It is precisely in this area that HMOs are generally found to offer superior services.

If, as this and other studies suggest, healthier individuals tend to choose the HMO, then some of the favorable utilization and cost experience that the literature has documented may be an effect of the initial differences between the enrollees in the different types of plans, rather than entirely the result of the organizational incentives of the health benefit plan itself.

Since 1983, GM employees at the company's urging have begun to select the HMO option more frequently. GM currently offers a preferred provider organization (PPO) as well. It is even more important now to GM to develop the tools necessary to understand how the new programs affect the overall health care risk. While the data analyzed in this study provide some interesting and provocative insights into factors influencing the choice of health benefit plan among their hourly blue collar workers, many questions remain unanswered.

To explore more fully the factors influencing choice of health plan, as well as the effects of HMOs on worker absence, existing data collection needs to be improved to provide information in three general areas: the health status and prior health care utilization of the worker; family structure, including health benefit coverage through

a spouse's employment, the work status of the spouse and the health status of the spouse or other family members; and better measures of worker absence.

Without data from either the HMO or traditional indemnity plan regarding the utilization behavior of enrolled employees, it is impossible for a business, large or small, to determine the cost-effectiveness of any plan selection, unless it compiles its own data. Findings of the GM study suggest, for example, that employers might conduct periodic surveys of health status and health care utilization of workers and their families in order to monitor adverse risk effects of alternative health plan choices. To assure the validity of responses and to protect the confidentiality of worker responses in sensitive areas, it is desirable to have such surveys conducted by outside researchers.

Employers also should review their internal data files for purposes of improving the manner in which data on worker absences are collected and monitored. At a minimum, reasons for absences related to illness or seeking health care should be coded differently from other causes in the data files.

Two of the four HMOs in the GM study kept employer specific data on both inpatient and outpatient utilization, and all of the HMOs kept provider utilization profiles for the purposes of internal management. In two of the HMOs, ambulatory visits per enrollee averaged 2.5 per year, which was considerably below the reported national average of 4 to 4.5 visits per enrollee per year in all systems of care.

There was no evidence that any of the HMOs limited access through excessive waiting periods for appointments. In all cases, urgent problems were seen the same day or next day. Requests for nonurgent appointments were honored within two weeks at the most. Patients rarely were kept waiting for more than 30 minutes after their appointment time. The low rate of ambulatory visits, along with the consistently reported reductions in hospitalization days per 1,000 enrollees, should result in lower premium dollars spent by the employer (see table). However, in each case, the HMO premium was only a few dollars less than the indemnity plan premium.

Elsewhere in the HMO community, data collection is less prevalent. For instance, at a March 1985 meeting in Chicago of the Midwest Business Group on Health, two Illinois based HMO officials stated that no data on utilization of office visits were kept. They argued that employer specific utilization was irrelevant to the HMOs because the HMOs community rate and do not base their premiums on the individual company's experience.

Small Employers Disproportionally Affected

The selection of the HMO option by the youngest and presumably healthiest employees is particularly devastating to smaller employers. Many employers of 100 to 2,000 workers, when an HMO option is offered, find that their indemnity premiums skyrocket as older, chronically ill employees with an established physician relationship tend to remain on the indemnity plan.

Many smaller corporations that self-insure are using pooled statistics from their third party administrators to analyze retrospectively employee utilization of health benefits. While smaller employers have a difficult time managing the health care risk due to insufficient data and lack of staff for analysis, both large and small employers have similar problems with regard to HMO enrollment and operation. Most HMO marketing efforts are directed toward an employer's younger and healthier employees and, consequently, are more likely to enroll such members, leaving a disproportionate number of the older and sicker individuals in an employer's indemnity plan.

HMO Characteristics by Site
1983

Site	HMO Type	Membership	Penetration Rate (percent)	HMO Hospital Days/1,000	Blue Cross Hospital Days/1,000
Private-nonprofit ownership					
Flint	IPA	70,000	24.5%	450	800 to 1,000
Detroit	Group-staff	130,000	8.2	500	800 to 1,000
Blue Cross-Blue Shield					
Saginaw	Group-staff	28,800	9.7	400	800 to 1,000
Rochester	Group-staff	35,500	22.8	324	500

Source: G.R. Winsberg and J. Vidmar, "Absenteeism and Health Care," (Final Report, The John A. Hartford Foundation: New York City, March 1985).

In larger companies, as well, this has been a problem. For example, this type of adverse selection occurred against the indemnity plan offered by J.C. Penney & Co. to its employees. The company has been a strong supporter of HMOs since the late 1970s. However, this past spring, one of the 145 HMOs offered to Penney employees unilaterally terminated medical coverage for 1,400 Atlanta area employees because it believed that a rate change requiring larger out-of-pocket employee contributions for HMO coverage would result in the loss of the younger, healthier members from its enrollment population, leaving behind those members who most needed medical care.

Good benefit design that allows an employer to fully reward sound case management by individual employees' personal physicians in the long run may be more advantageous to the employer than endorsing an HMO option. For example, adequate incentives to use the full panoply of home care options in order to shorten or eliminate hospital stays should be included along with recognition that employee education must keep apace of the rapidly occurring changes in the health care system.

Through the formation of business coalition user groups, consisting of employers using the same insurer or third party administrator who work together to extract and analyze claims information on employees' use of health services, some of the secrets of health care are being yielded (BUSINESS AND HEALTH, March 1985, p. 12-16). These secrets, however, are being unraveled only to those employers large enough to hire the cast of medical counselors, statisticians and analysts necessary to translate these data into action plans. Many smaller companies do not have the internal resources to manage the health care benefit risk effectively and will have to consider seriously how to meet this challenge. ■

EXHIBIT 5
DATE 3-20-87
HB 353

Montana Psychological Association

Testimony on SB 353
March 20, 1987

The Montana Psychological Association represents 200 professional psychologists in the state of Montana in private and public sector mental health care. Out of its concern for cost-effective, innovative mental health care and for protected freedom of choice for Montana health care consumers, the MPA supports Senate Bill 353 with the addition of strengthening amendments.

The rising expenditures for health care in the U.S. to over $465 billion have led to unprecedented steps to control health care costs through new cost-efficient ways of doing business with health care providers. Health Maintenance Organizations pose not only innovative opportunities but also significant challenges to you as you develop an HMO statute for the state of Montana.

In some other states certain practices of HMO's restrict the delivery of mental health care only to selected physicians, denying psychologists the opportunity to be fully participating members and also limiting the consumer's choice in mental health care.

In addition some HMO's limit the opportunity for health care professional other than physicians to participate on governing boards and policymaking bodies handling the administration of these organizations.

Profit incentives that are given directly to individual "gatekeepers" in HMO's also run the risk of dictating lower levels of good patient care. Consumers are often unaware of the profit incentives and cost containment mandates under which "gatekeeper" physicians operate.

The MPA, therefore supports SB 353 with the addition of strengthening anti-discrimination amendments on incentive plans, freedom of choice provisions when patients are referred-out. We offer the following two amendments of our own:

1. "Interdisciplinary boards and panels" - HMO's in this state shall have governing boards or similar utilization panels that are multidisciplinary, and may include providers or other individuals, or both." (Rewording of Section 6 (1) [p. 18, line 21+]

   (The inclusion of multidisciplinary professionals would make it possible for mental health care providers in addition to physicians to participate in the administration of HMO's)

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2. Addition of words "coverage and" after words "accordance with the..." in Sect 8, (3) (f) [p. 2], line 14.

(This clarifies that the coverage for mental illness, drug and alcohol treatments is included, not just the "limits" as listed in 33-22-703.)

The MPA stands in opposition to any amendments that would require all employers in the state of Montana with 25 or more employees to offer an HMO plan if they already offer a group insurance plan. We feel this is a serious financial burden to place on employers of this sector across our state.

We recognize that this is a significant piece of legislation and it is important that a strong bill be developed for our state and our health care consumers. We will work with the Committee and its subcommittee to perfect and pass a strong Montana HMO statute.

Thank you for your consideration of our concerns and the amendments we offer.

Dr. Ann Princes, practicing
psychologist in Helena

Pat Callbeck Harper
lobbyist for MPA

EXHIBIT 6
DATE 3-20-87
HB SB 353

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Suite 12 • Helena, Montana 59601

POSITION PAPER ON
SENATE BILL #353

The Montana Medical Association supports Senate Bill #353 as amended. Despite the fact SB #353 may contain certain provisions which the Medical Association would have an interest in seeing amended, SB #353 represents a recognition by the legislature that HMOs as alternative delivery systems need to be dealt with in a different regulatory manner than the traditional third party payment systems offered by insurers or health service corporations.

The history of health maintenance organizations have shown that it is important that legislators recognize the distinction between the traditional health insurance products offered by the insurers and health service corporations and HMOs as alternative delivery systems. While HMO and PPO products are often offered by insurers and health service corporations, this area has also opened up to joint ventures such as combinations between hospitals and clinics and/or state or local medical associations. These groups do not provide the traditional means of prepayment of medical expenses but would be eligible if properly structured and financed to receive a certificate of authority and operate HMOs. Numerous hospital corporations such as Humana have started HMOs in a number of states and state medical societies including Georgia and South Dakota have started statewide IPA HMOs. In addition, there are numerous physician groups across

the country that are not federally qualified HMOs but have started HMOs which have a localized service area.

Senate Bill #353 is legislation with far-reaching consumer ramifications. Without the statutory enabling legislation of Senate Bill #353, the field of those who would be eligible to start HMOs would be restricted. It is the opinion of the Montana Medical Association that absent HMO legislation similar to Senate Bill #353, the only parties that would be in a position to start HMOs in the State of Montana would be insurers and health service corporations who do business in the State of Montana or who qualify to do business in Montana and who would meet statutory requirements for doing business in the State of Montana. Meeting the requirements to do business as an insurer or health service corporation in the State of Montana are considerably different than the requirements found in this HMO legislation. Senate Bill #353 allows parties in addition to insurers and health service corporations to present to the Division of Insurance an application for a Certificate of Authority to operate HMOs. The applications must set out information such as projections as to enrollment, market projections, and administrative costs which will allow the Division of Insurance to make some decisions concerning the reserve requirement necessary to start such an HMO and to impose other reasonable requirements to insure the continued viability of HMOs. The continued solvency of HMOs are critical to the consumers of Montana who choose alternative delivery systems such as HMOs over traditional insurers.

It is not the intent of this position paper to indicate that any HMO products presently being offered in this state are not financially viable; however, it is the position of the Montana Medical Association that it is important to the consuming public that there is preserved the method by which other parties may enter the HMO market and that any alternative delivery system which they become associated with remain a financially viable product. This statute allows other parties the ability to enter the HMO market and provides for the continued monitoring of the operation of HMOs by the filing of a number of annual reports which will provide the Division of Insurance with a means to track the continued growth of the HMO. In addition, the means will be provided to insure HMOs are properly funded and meeting the needs of the consumer who has chosen that product.

Absent specific HMO enabling legislation the field of players in the HMO market in this state would be limited and it would be the position of the Montana Medical Association that limiting the participants in this field is not in the best interests of either the State of Montana nor the consuming public. Therefore, the Montana Medical Association would urge that Senate Bill #353 as presented to the Committee be adopted with the inclusion of any necessary amendment the Committee feels is necessary and that over the period of the next two years that the participants in the alternative delivery systems, together with the Division of Insurance, work towards agreement on statutory language which will meet the concerns of all involved.

Thank you.

EXHIBIT 7
DATE 3-30-91
HB SB353

PROPOSED AMENDMENTS TO SENATE BILL 353

Senate Bill 353, Third Reading Copy, is hereby amended as follows:

1. Page: Statement of Intent, page 2
   Following: Line 11
   Strike: Lines 12 through 14

2. Page: 10
   Line: Following line 15
   Strike: Lines 16 through 20
   Insert: "name the person and describe:"

3. Page: 12
   Line: Following line 25
   Insert: "(7) The commissioner may make reasonable rules exempting an insurer or health service corporation operating a health maintenance organization as a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner under other laws and rules administered by the commissioner."

4. Page: 18
   Line: 3
   Following: "may"
   Insert: ", after notice and hearing,"

5. Page: 18
   Line: 4
   Following: "power"
   Insert: "under subsection (1)(a), (1)(b), or (1)(d)"

6. Page: 18
   Line: Following line 9
   Strike: Lines 10, 11 and "commissioner." on line 12

7. Page: 20
   Line: 18
   Following: "that is"
   Strike: "unjust, unfair, inequitable,"

8. Page: 20
Line: 19
Following: "deceptive;"
Strike: "that encourages misrepresentation;"

9. Page: 26
Line: 3
Following: "within"
Strike: "a reasonable period"
Insert: "60 days"

10. Page: 26
Line: 6
Following: "form"
Strike: "or use a schedule of charges"

11. Page: 26
Line: 7
Following: "form"
Strike: "or the health maintenance organization files the schedule of charges"

12. Page: 26
Line: 15
Following: "any"
Insert: "relevant"

13. Page: 29
Line: 4
Strike: Lines 4 and 5 and renumber all subsequent subsections.

14. Page: 29
Line: 22
Following: "subsection (1)(d)"
Strike: "(iii)
Insert: "(ii)"

15. Page: 29
Line: 24
Following: "regulations."
Strike: "A"
Insert: "Except for a health maintenance organization operated as a plan by a health service corporation under title 33, chapter 30,"

16. Page: 39
Line: 10
Following: "title"
Insert: "or licensed as an enrollment representative under 33-30-311 through 313"

17. Page: 41
Line: 17
Following: "every"
Strike: "3"
Insert: "4"

18. Page: 41
Line: 25
Following: "every"
Strike: "3"
Insert: "4"

19. Page: 43
Line: 25
Following: "[section 3],"
Insert: "and provided that such operation adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner,"

EXHIBIT 8
DATE 3-20-87
HB SB 353

HMO
Montana

Helena Office
P.O. Box 8064
34 N. Last Chance Gulch
Helena, MT 59604
(406) 444-8250

Missoula Office
P.O. Box 8356
2505 Russell
Missoula, MT 59807
(406) 721-6004

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HMO
Montana

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VISITORS' REGISTER

BUSINESS AND LABOR COMMITTEE

BILL NO. SENATE BILL NO. 353 DATE MARCH 20, 1987

SPONSOR SENATOR DARRYL MEYER

NAME (please print)	REPRESENTING	SUPPORT	OPPOSE
Ben J Lansing	Mt. Medical Assn	✓	
Pat Callbeck Harper	MT Psychological Assoc	✓	
JUDITH H CARLSON	MT CH. NASW		
Bill McDonald	Group Health Plan Mont	✓	
Steve Walker	Mental Health Centers	X	
Dennis Duncan	Montana Medical Assoc	✓	
JAMES W. BORCHARDT	STATE AUDITOR	✓	
MT Optometric Assoc	MT Optometric Assoc	✓	
Jay McGrath	Mental Health Assoc	X	
William Evans	Montana NASW	X	
Mike Murray	Chemical Dependency Programs of MT.	X	
Steve Brown	Blue Cross-Blue Sh.	✓	
Jed V. Davey	MT. Mental Health Counselors Assn	✓	
Joan Kebisch	MT Mental Health Couns.	✓	
Mona Jamison	LMTC	✓	
Ann Scott	RMTC	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

MINUTES OF THE MEETING
BUSINESS AND LABOR COMMITTEE
50TH LEGISLATIVE SESSION

March 26, 1987

The meeting of the Business and Labor Committee was called to order by Chairman Les Kitselman on March 26, 1987 at 9:00 a.m. in Room 312-F of the State Capitol.

ROLL CALL: All members were present.

EXECUTIVE ACTION

ACTION ON HOUSE BILL 461

Rep. Dennis Nathe requested that House Bill No. 461 BE TABLED. The motion carried with three opposed.

ACTION ON SENATE BILL 353

Rep. Thomas moved SB 353 BE CONCURRED IN. Rep. Thomas moved to adopt the committee report and amendments. Chairman Kitselman discussed the amendments and mentioned that the Montana Psychological Association wanted to make sure that the board consisted of multi-disciplinary fields. He said the State Auditors language was accepted as amendment to the bill.

Rep. Brown commented that all the people had agreed to the amendments. The question was called. The motion carried with Reps. Jones and Brandewie opposed.

The question was called on the motion to be concurred as amended. The motion carried with Reps. Brandewie and Jones opposed.

ACTION ON SENATE BILL 371

Chairman Kitselman pointed out that one amendment on page 5 to page 6 that was not agreed on by the committee. Exhibit No. 1.

He said that was suggested by Steve Waldron but is the crux of what a preferred provider is. He said to compare the two programs, the health maintenance organization is a group of people that prepay and are assigned to a certain member health service group. The preferred provider organization are given a 25 percent differential in their medical charges and is selective on who belongs. He said the bill says a health care insurer may not deny a provider who agrees to the terms. He questioned whether the provider denied that

DAILY ROLL CALL

BUSINESS & LABOR COMMITTEE

50th LEGISLATIVE SESSION -- 1987

Date 3-26-87

NAME	PRESENT	ABSENT	EXCUSED
REP. LES KITSELMAN, CHAIRMAN	✓		
REP. FRED THOMAS, VICE-CHAIRMAN	✓		
REP. BOB BACHINI	✓		
REP. RAY BRANDEWIE	✓		
REP. JAN BROWN	✓		
REP. BEN COHEN	✓		
REP. JERRY DRISCOLL	✓		
REP. WILLIAM GLASER	✓		
REP. LARRY GRINDE	✓		
REP. STELLA JEAN HANSEN	✓		
REP. TOM JONES	✓		
REP. LLOYD MCCORMICK	✓		
REP. GERALD NISBET	✓		
REP. BOB PAVLOVICH	✓		
REP. BRUCE SIMON	✓		
REP. CLYDE SMITH	✓		
REP. CHARLES SWYSGOOD	✓		
REP. NORM WALLIN	✓		

CS-30

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STANDING COMMITTEE REPORT

EXHIBIT_____
DATE 3-26
HB SB 353

MARCH 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 353

☐ do pass
☐ do not pass

☒ be concurred in
☐ be not concurred in

☒ as amended
☐ statement of intent attached

REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Title, line 7
Following: "33-22-111"
Insert: "17-7-502,"

2) Page 10, line 18
Strike: "for approval"

3) Page 10, line 19
Following: "[section 8(7)]"
Insert: ", however, nothing in this subsection deprives the health maintenance organization of its right to confidentiality of any proprietary information and the commissioner may not disclose that proprietary information to any other person"

4) Page 13, line 1
Following: Page 12, line 25
Insert: "(7) The commissioner may make reasonable rules exempting an insurer or health service corporation operating a health maintenance organization as a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner under other laws and rules administered by the commissioner."

5) Page 18, line 3
Following: "may"
Insert: ", after notice and hearing, within 60 days."

6) Page 18, line 4
Following: "power"
Insert: "under subsection (1)(a), (1)(b), or (1)(d)"

7) Page 18, lines 10, 11, and 12
Strike: lines 10 and 11 in their entirety and line 12 through "commissioner."

REP. KITSELMAN will sponsor

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8) Page 20, lines 18 and 19
Following: "is" on line 18
Strike: the remainder of line 18 and line 19 in its entirety

9) Page 23, line 1
Following: "limits"
Insert: "and coverage"

10) Page 23, line 2
Strike: "33-22-703;"
Insert: "Title 33, chapter 22, part 7, however, after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction.
(i) If an enrollee chooses a provider other than the health maintenance organization provider for such treatment and referral services, the enrollee's designated provider must limit his treatment and services to the scope of the referral in order to receive payment from the health maintenance organization.
(ii) The amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services."

11) Page 25, line 18, through page 26, line 2
Following: Page 25, line 17
Strike: lines 18 through 25 on page 25 and lines 1 and 2 on page 26 in their entirety

12) Page 26, lines 3 and 4
Strike: "a reasonable period"
Insert: "60 days"

13) Page 26, line 6
Strike: "or use a schedule of charges"

14) Page 26, lines 7 and 8
Following: "form" on line 7
Strike: the remainder of line 7 and line 8 through "charges."

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15) Page 26, line 15
Following: "any"
Insert: "relevant"

16) Page 29, line 24
Strike: "A"
Insert: "Except for a health maintenance organization operated as a plan by a health service corporation, a"

17) Page 39, line 10
Following: "title"
Insert: "or licensed as an enrollment representative under 33-30-311 through 33-30-313"

18) Page 41, lines 13 through 15
Following: "organization" on line 13
Strike: the remainder of line 13, line 14 in its entirety and line 15 through "arrangements"

19) Page 43, line 25
Following: "(section3)
Insert: "and provided that such operation adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner"

20) Page 47, line 21
Strike: "quality"
Insert: "availability, accessibility, and continuity"

21) Page 49, line 9
Following: "$35"
Insert: ";
(d) for annual continuation of certificate of authority, $300"

22) Page 49, lines 20 and 21
Following: "17-7-502." on line 20
Strike: the remainder of line 20 and line 21 in its entirety
Insert: "Such fees are statutorily appropriated to the department of health as provided in 17-7-502."

23) Page 60, line 6
Following: line 5
Insert: "Section 30. Section 17-7-502, MCA, is amended to read:

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"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;
(b) 2-17-105;
(c) 2-18-812;
(d) 10-3-203;
(e) 10-3-312;
(f) 10-3-314;
(g) 10-4-301;
(h) 13-37-304;
(i) 15-31-702;
(j) 15-36-112;
(k) 15-70-101;
(l) 16-1-404;
(m) 16-1-410;
(n) 16-1-411;
(o) 17-3-212;
(p) 17-5-404;
(q) 17-5-424;
(r) 17-5-804;
(s) 19-8-504;
(t) 19-9-702
(u) 19-9-1007;
(v) 19-10-205;
(w) 19-10-305;
(x) 19-10-506;
(y) 19-11-512;
(z) 19-11-513;
(aa) 19-11-606;
(bb) 19-12-301;
(cc) 19-13-604;
(dd) 20-6-406;

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(ee) 20-8-111;
(ff) 23-5-612;
(gg) [section 17];
(hh) [section 22];
(ii) 37-51-501;
(jj) 53-24-206;
(kk) 75-1-1101;
(ll) 75-7-305;
(mm) 80-2-103;
(nn) 80-2-228;
(oo) 90-3-301;
(pp) 90-3-302;
(qq) 90-15-103; and
(rr) Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments."

Renumber: subsequent sections

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STATEMENT OF INTENT

SB 353 - BLUE COPY

AMENDMENTS AS FOLLOWS:

1) Page 7

Strike: lines 9 through 14 in their entirety

Insert: "Any rule promulgated by the commissioner in regard to advisory boards of health maintenance organizations must require the membership of those advisory boards to multidisciplinary representatives."

Chairman.

STATE PUB. CO.
Helena, Mont.

3-26-87
EXHIBIT
DATE SB 353

STATEMENT OF INTENT

SENATE BILL 353

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because:

(1) it authorizes the commissioner of insurance of the state of Montana (commissioner) and the department of health and environmental sciences to adopt, after notice and hearing, reasonable rules necessary or proper to effectuate sections 1 through 29;

(2) section 3 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner describing material modifications of information required in an application for a certificate of authority if the commissioner considers the information unnecessary; and

(3) section 5 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner before exercising the powers granted in subsection (1)(a), (1)(b), or (1)(d) if the commissioner believes exercising those powers will have de minimis effect. The legislature expects the commissioner to make only reasonable rules necessary to effectuate or aid the effectuation of sections 1 through 29.

(over)

The legislature does not authorize the commissioner to adopt rules that extend, modify, or conflict with either any law of this state or any reasonable implications of those laws. If reasonably possible, the commissioner shall set forth a proposed rule or amendment to a rule in or with the required notice of hearing. No rule or amendment to a rule by the commissioner is effective until it has been on file in the commissioner's office for at least 10 days.

~~In--adopting--rules-prescribing-investment-regulations, the-commissioner-shall-use-the-NAIC-Model-Health-Maintenance Organization-Investment-Guidelines.~~

~~The-commissioner-and-the-department-are-urged--to--look to---regulations--adopted--by--the--state--of--Minnesota--in implementing-chapter-62D-of-the-Minnesota-insurance-code.~~

ANY RULE PROMULGATED BY THE COMMISSIONER IN REGARD TO ADVISORY BOARDS OF HEALTH MAINTENANCE ORGANIZATIONS MUST REQUIRE THE MEMBERSHIP OF THOSE ADVISORY BOARDS TO INCLUDE MULTIDISCIPLINARY REPRESENTATIVES.

Statement of Intent

SB 353 - Yellow Copy

1. Page 2,

Strike: lines 9 through 14 in their entirety

Insert: "Any rule promulgated by the commissioner in regard to advisory boards of health maintenance organizations must require the membership of those advisory boards to be multidisciplinary representatives."

LLC

SB 353 - yellow copy

1. Title, line 7
Following: "~~33-22-111~~"
Insert: "17-7-502,"

2. Page 10, line 18
Strike: "for approval"

3. Page 10, line 19
Following: "[section 8(7)]"
Insert: ", however, nothing in this subsection deprives the health maintenance organization of its right to confidentiality of any proprietary information and the commissioner may not disclose that proprietary information to any other person"

4. Page 13, line 1
Following: page 12, line 25
Insert: "(7) The commissioner may make reasonable rules exempting an insurer or health service corporation operating a health maintenance organization or a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner

under other laws and rules administered by the commissioner."

5. Page 18, line 3
Following: "may"
Insert: ", after notice and hearing, within 60 days

6. Page 18, line 4
Following: "power"
Insert: "under subsection (1)(a), (1)(b), or (1)(d)"

7. Page 18, lines 10, 11, and 12
Strike: lines 10 and 11 in their entirety and line 12 through "commissioner."

8. Page 20, lines 18 and 19
Following: "is" on line 18
Strike: the remainder of line 18 and line 19 in its entirety

9. Page 23, line 1
Following: "limits"
Insert: "and coverage"

10. Page 23, line 2
Strike: "33-22-703"
Insert: "Title 33, chapter 22, part 7; however, a health maintenance organization may

limit an enrollee to a health maintenance organization provider for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction"

[This amendment to be further modified upon agreement between concerned parties]

11. Page 25, line 18, through page 26, line 2
Following: Page 25, line 17
Strike: lines 18 through 25 on page 25 and lines 1 and 2 on page 26 in their entirety

13. Page 26, line 6
Strike: "or use a schedule of charges"

14 Page 26, lines 7 and 8
Following: "form" on line 7
Strike: the remainder of line 7 and line 8 through "charges."

12. Page 26, lines 3 and 4
Strike: "a reasonable period"
Insert: "60 days"

15 Page 26, line 15
Following: "any"
Insert: "relevant"

SB 353 - page 4

16. Page 29, line 24
Strike: "A"
Insert: "Except for a health maintenance organization operated as a plan by a health service corporation, a"

17. Page 39, line 3
Following: line 2
Insert: "(8) A health maintenance organization may not knowingly offer direct incentive payments or direct disincentive payment reductions to a physician as an inducement to limit services. As used in this subsection, "direct" means ... [language to be inserted]."

18. Page 39, line 10
Following: "title"
Insert: "or licensed as an enrollment representative under 33-30-311 through 33-2-31

19. Page 41, lines 13 through 15
Following: "organization" on line 13
Strike: the remainder of line 13, line 14 in its entirety and line 15 through "arrangements"

20. Page 43, line 25
Following: "[section 3]
Insert: "and provided that such operation

adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner"

21. Page 47, line 21
Strike: "quality"
Insert: "availability, accessibility, and continuity

22. Page 49, line 9
Following: "#25"
Insert: ";
(2) for annual continuation of certificate of authority, #300"

Insert carried forward to page 6.

24. Page 60, line 6
Following: line 5
Insert: "Section 30. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations — definition — requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

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(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;
(b) 2-17-105;
(c) 2-18-812;
(d) 10-3-203;
(e) 10-3-312;
(f) 10-3-314;
(g) 10-4-301;

SB 353 - page 6

(h) 13-37-304;
(i) 15-31-702;
(j) 15-36-112;
(k) 15-70-101;
(l) 16-1-404;
(m) 16-1-410;
(n) 16-1-411;
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(p) 17-5-404;
(q) 17-5-424;
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(s) 19-8-504;
(t) 19-9-702;
(u) 19-9-1007;
(v) 19-10-205;
(w) 19-10-305;
(x) 19-10-506;
(y) 19-11-512;
(z) 19-11-513;
(aa) 19-11-606;
(bb) 19-12-301;
(cc) 19-13-604;
(dd) 20-6-406;
(ee) 20-8-111;
(ff) 23-5-612;
(gg) [section 17];
(hh) [section 22];
(ii) ~~(gg)~~ 37-51-501;
(jj) ~~(hh)~~ 53-24-206;
(kk) ~~(ii)~~ 75-1-1101;
(ll) ~~(jj)~~ 75-7-305;
(mm) ~~(kk)~~ 80-2-103;
(nn) ~~(ll)~~ 80-2-228;
(oo) ~~(mm)~~ 90-3-301;
(pp) ~~(nn)~~ 90-3-302;
(qq) ~~(oo)~~ 90-15-103; and
(rr) ~~(pp)~~ Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments. "

Renumber: subsequent sections

23. Page 49, line 20 and 21

Following: "~~17-7-502~~." on line 20

Strike: the remainder of line 20 and line 21 in its entirety

Insert: " Such fees are statutorily appropriated to the

ent page 5

department of health as provide
in 17-7-502."

3-26-87
EXHIBIT
DATE 3-26
SB 353

STATEMENT OF INTENT

SENATE BILL 353

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because:

(1) it authorizes the commissioner of insurance of the state of Montana (commissioner) and the department of health and environmental sciences to adopt, after notice and hearing, reasonable rules necessary or proper to effectuate sections 1 through 29;

(2) section 3 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner describing material modifications of information required in an application for a certificate of authority if the commissioner considers the information unnecessary; and

(3) section 5 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner before exercising the powers granted in subsection (1)(a), (1)(b), or (1)(d) if the commissioner believes exercising those powers will have de minimis effect. The legislature expects the commissioner to make only reasonable rules necessary to effectuate or aid the effectuation of sections 1 through 29.

The legislature does not authorize the commissioner to adopt rules that extend, modify, or conflict with either any law of this state or any reasonable implications of those laws. If reasonably possible, the commissioner shall set forth a proposed rule or amendment to a rule in or with the required notice of hearing. No rule or amendment to a rule by the commissioner is effective until it has been on file in the commissioner's office for at least 10 days.

~~In--adopting--rules-prescribing-investment-regulations,~~ ~~the-commissioner-shall-use-the-NAIC-Model-Health-Maintenance Organization-Investment-Guidelines.~~

~~The-commissioner-and-the-department-are-urged--to--look to---regulations--adopted--by--the--state--of--Minnesota--in implementing-chapter-62B-of-the-Minnesota-insurance-code.~~

ANY RULE PROMULGATED BY THE COMMISSIONER IN REGARD TO ADVISORY BOARDS OF HEALTH MAINTENANCE ORGANIZATIONS MUST REQUIRE THE MEMBERSHIP OF THOSE ADVISORY BOARDS TO INCLUDE MULTIDISCIPLINARY REPRESENTATIVES.

SENATE BILL NO. 353

INTRODUCED BY MEYER, LORY, BENGTSON, MILLER, MCLANE, SANDS

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE FORMATION AND OPERATION OF HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS ~~17-7-502 AND 33-22-111~~ 17-7-502, 33-1-102 AND 33-1-704, MCA; AND PROVIDING AN ~~IMMEDIATE~~ EFFECTIVE DATE AND AN APPLICABILITY PROVISION."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Short title. This act may be cited as the "Montana Health Maintenance Organization Act".

NEW SECTION. Section 2. Definitions. As used in [sections 1 through 29], unless the context requires otherwise, the following definitions apply:

(1) "Agent" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(2) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

(e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to [section 8(3)(e)];

(F) CARE AND TREATMENT OF MENTAL ILLNESS, ALCOHOLISM, AND DRUG ADDICTION;

~~(f)~~(G) diagnostic laboratory and diagnostic and therapeutic radiologic services; and

~~(g)~~(H) preventive health services, including:

(i) immunizations;

(ii) well-child care from birth;

(iii) periodic health evaluations for adults;

(iv) voluntary family planning services;

(v) infertility services; and

(vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction.

(3) "Commissioner" means the commissioner of insurance of the state of Montana.

(4) "Department of health" means the department of health and environmental sciences provided for in 2-15-2101.

(5) "Director" means the director of the department of health and environmental sciences provided for in 2-15-2102.

(6) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

(7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(8) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

(9) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(10) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers.

(11) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(12) "PLAN" MEANS A HEALTH MAINTENANCE ORGANIZATION OPERATED BY AN INSURER OR HEALTH SERVICE CORPORATION AS AN INTEGRAL PART OF THE CORPORATION AND NOT AS A SUBSIDIARY.

~~(12)~~(13) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of his practice or other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(13)~~(14) "Uncovered expenditures" mean the costs of

health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent.

NEW SECTION. Section 3. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with [sections 1 through 29]. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first obtains from the secretary of state a certificate of authority to transact business in this state as a foreign corporation under 35-1-1001.

(2) Each health maintenance organization operating in this state as of [the effective date of this act] shall submit an application for a certificate of authority under subsection (3) within 30 days ~~of-[the-effective-date-of-this act]~~ AFTER THE EFFECTIVE DATE OF RULES ADOPTED BY THE COMMISSIONER AND THE DEPARTMENT OF HEALTH AS PROVIDED IN [SECTION 20]. Each such applicant may continue to operate in this state until the commissioner acts upon the application. If an application is denied under [section 4], the applicant

must be treated as a health maintenance organization whose certificate of authority has been revoked.

(3) Each application of a health maintenance organization, whether separately licensed or not, for a certificate of authority must:

(a) be verified by an officer or authorized representative of the applicant;

(b) be in a form prescribed by the commissioner;

(c) contain:

(i) the applicant's name;

(ii) the location of the applicant's home office or principal office in the United States (if a foreign person);

(iii) the date of organization or incorporation;

(iv) the form of organization (including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors);

(v) the state or country of domicile; and

(vi) any additional information the commissioner may reasonably require; and

(d) set forth the following information or be accompanied by the following documents, as applicable:

(i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership

agreement, trust agreement, or other applicable documents, and all amendments thereto, certified by the public officer with whom the originals were filed in the state or country of domicile;

(ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the applicant's internal affairs, certified by its secretary or other officer having custody thereof;

(iii) a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation; and the partners or members in the case of a partnership or association;

(iv) a copy of any contract made or to be made between:

(A) any provider and the applicant; or

(B) any person listed in subsection (3)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

(v) the extent to which any of the following will be included in provider contracts and the form of any provisions that:

(A) limit a provider's ability to seek reimbursement

for basic health care services or health care services from an enrollee;

(B) permit or require a provider to assume a financial risk in the health maintenance organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

(C) govern amending or terminating an agreement with a provider;

(vi) a financial statement showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of [sections 1 through 29].

(vii) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other source of funding;

~~(viii) a summary of feasibility studies or marketing surveys that support the financial and enrollment~~

~~projections--for-the-plan,-including-the-potential-number-of enrollees-in-the-operating-territory,-the--projected--number of--enrollees--for--the--first--5--years,--the--underwriting standards-to-be-applied,-and-the--method--of--marketing--the organization;~~

~~(ix)~~(VIII) a power of attorney executed by the applicant, on a form prescribed by the commissioner, appointing the commissioner, his successors in office, and his authorized deputies as the applicant's attorney to receive service of legal process issued against it in this state;

~~(x)~~(IX) a statement reasonably describing the geographic service area or areas to be served by county, including:

(A) a chart showing the number of primary and specialty care providers with locations and service areas by county;

(B) the method of handling emergency care, with the location of each emergency care facility; and

(C) the method of handling out-of-area services;

~~(xi)~~(X) a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

~~(xiii)~~(XI) a description of the complaint procedures to be used as required under [section 11];

~~(xiv)~~(XII) a description of the procedures and programs to be implemented to meet the quality of health care requirements in [section 4];

~~(xv)~~(XIII) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under [section 6];

~~(xvi)~~(XIV) a summary of the way in which administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed ~~for approval~~ with the commissioner in accordance with the filing provisions of [section 8(7)], HOWEVER, NOTHING IN THIS SUBSECTION DEPRIVES THE HEALTH MAINTENANCE ORGANIZATION OF ITS RIGHT TO CONFIDENTIALITY OF ANY PROPRIETARY INFORMATION, AND THE COMMISSIONER MAY NOT DISCLOSE THAT PROPRIETARY INFORMATION TO ANY OTHER PERSON. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

(C) the method of payment, including any provisions for the administrator to participate in the profits or losses of the plan;

(D) the duration of the contract; and

(E) any provisions for modifying, terminating, or renewing the contract.

~~(xvi) a summary of current and projected enrollment, income from premiums by type of payer, other income, administrative and other costs, the projected break-even point (including the method of funding the accumulated losses until the break-even point is reached), and the assumptions made in developing projected operating results;~~

~~(xvii)~~ (XV) a summary of all financial guaranties by providers, sponsors, affiliates, or parents within a holding company system or any other guaranties that are intended to ensure the financial success of the plan, including hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

~~(xviii)~~ (XVI) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

~~(xix)~~ (XVII) evidence that it can meet the requirement of [section 13(10)]; and

~~(xx)~~ (XVIII) any other information that the commissioner

may reasonably require to make the determinations required in [section 4].

(4) Each health maintenance organization shall file each substantial change, alteration, or amendment to the information submitted under subsection (3) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may, AFTER NOTICE AND HEARING, disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may make reasonable rules exempting from the filing requirements of this subsection those items he considers unnecessary.

(5) An applicant or a health maintenance organization holding a certificate of authority shall file with the commissioner all contracts of reinsurance and any modifications thereto. An agreement between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A reinsurance agreement must remain in full force and effect for at least 90 days following written notice of cancellation by either party by certified mail to the commissioner.

(6) Each health maintenance organization shall maintain, at its administrative office, and make available to the commissioner upon request executed copies of all provider contracts.

(7) THE COMMISSIONER MAY MAKE REASONABLE RULES EXEMPTING AN INSURER OR HEALTH SERVICE CORPORATION OPERATING A HEALTH MAINTENANCE ORGANIZATION AS A PLAN FROM THE FILING REQUIREMENTS OF THIS SECTION IF INFORMATION REQUESTED IN THE APPLICATION HAS BEEN SUBMITTED TO THE COMMISSIONER UNDER OTHER LAWS AND RULES ADMINISTERED BY THE COMMISSIONER.

NEW SECTION. Section 4. Issuance of certificate of authority. (1) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall transmit copies of the application and accompanying documents to the department of health. The department of health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished, has:

(a) demonstrated the willingness and potential ability to assure that it will provide health care services in a manner assuring availability and accessibility of adequate personnel and facilities and enhancing availability, accessibility, and continuity of service;

(b) arrangements, established in accordance with the rules made by the department of health, for an ongoing

quality assurance program concerning health care ~~processes and--outcomes~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY OF SERVICE; and

(c) a procedure, established in accordance with rules of the department of health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and any other matters as may be reasonably required by the department of health.

(2) Within ~~90~~ 60 days of receipt of the application from a health maintenance organization for issuance of a certificate of authority, the department of health shall certify to the commissioner that the proposed health maintenance organization meets the requirements of subsection (1) or shall, AFTER NOTICE AND HEARING, notify the commissioner that the health maintenance organization does not meet those requirements and specify in what respects it is deficient. The director may extend by not more than an additional 30 days the period within which he may certify to the commissioner that the proposed health maintenance organization meets or does not meet the requirements of subsection (1) by giving notice of the extension to the commissioner and the health maintenance organization before the expiration of the initial ~~90-day~~

60-DAY period.

(3) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to [section 3] within 180 days of receipt of the certification from the department of health. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in [section 22] if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent~~,-trustworthy,-and-of--good reputation~~ AND TRUSTWORTHY.

(b) The department of health certifies, in accordance with subsection (2), that the health maintenance organization's proposed plan of operation meets the requirements of subsection (1).

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

(d) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may in his discretion consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with [section 13]; and

(vi) any additional information as the commissioner may reasonably require.

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to [section 6].

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to [section 3] or by independent investigation, ~~is contrary to the public interest~~ VIOLATES ANY PROVISION OF [SECTIONS 1 THROUGH 29] OR RULES ADOPTED BY THE COMMISSIONER OR THE DEPARTMENT OF HEALTH.

(g) Any deficiencies identified by the department of health have been corrected.

(4) The commissioner may in his discretion deny a certificate of authority only if he complies with the requirements of [section 21].

NEW SECTION. Section 5. Powers of health maintenance organizations. (1) The powers of a health maintenance organization include but are not limited to the following:

(a) the purchase, lease, construction, renovation, operation, or maintenance of a hospital, a medical facility, or both, its ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(b) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation under its control for the purpose of acquiring or constructing a medical facility or hospital or in furtherance of a program providing health care services to enrollees;

(c) the furnishing of health care services through a provider who is under contract with or employed by the health maintenance organization;

(d) the contracting with a person for the performance on its behalf of certain functions, such as marketing,

enrollment, and administration;

(e) the contracting with an insurer authorized to transact insurance in this state, or with a health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization; and

(f) the offering of other health care services in addition to basic health care services.

(2) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner before exercising a power granted in subsection (1)(a), (1)(b), or (1)(d). The commissioner may, AFTER NOTICE AND HEARING, WITHIN 60 DAYS disapprove the exercise of a power UNDER SUBSECTION (1)(A), (1)(B), OR (1)(D) only if, in his opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. The commissioner may make reasonable rules exempting from the filing requirement of this subsection those activities having a de minimis effect. ~~The exercise of authority granted in subsections (1)(a), (1)(b), and (1)(d) is subject to disapproval by the commissioner.~~ The commissioner may exempt certain contracts from the filing requirement whenever exercise of the authority granted in

this section would have little or no effect on the health maintenance organization's financial condition and ability to meet obligations.

(3) Nothing in this section exempts the activities of a health maintenance organization from any applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 6. Governing body. (1) The governing body of a health maintenance organization may include providers or other individuals, or both.

(2) The governing body shall establish a mechanism to give the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

NEW SECTION. Section 7. Fiduciary responsibilities. (1) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in the manner of a fiduciary to the health maintenance organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be

prescribed by the commissioner. Each bond must be written with at least a 1-year discovery period and, if written with less than a 3-year discovery period, must contain a provision that a cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, may not take effect prior to the expiration of 90 days after written notice of the cancellation or termination has been filed with the commissioner unless the commissioner approves an earlier cancellation or termination date.

NEW SECTION. Section 8. Evidence of coverage and charges for health care services. (1) Every enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment

to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is ~~unjust, unfair, inequitable, misleading, or deceptive, that encourages misrepresentation, or that is~~ untrue, misleading, or deceptive as defined in [section 14(1)]. The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

(b) definitions of geographical service area,

emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment, which is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who

do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or his dependents;

(f) a provision ~~offering~~ REQUIRING medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits AND COVERAGE provided in ~~33-22-703;~~ TITLE 33, CHAPTER 22, PART 7; HOWEVER:

(I) AFTER THE PRIMARY CARE PHYSICIAN REFERS AN ENROLLEE FOR TREATMENT OF AND APPROPRIATE ANCILLARY SERVICES FOR MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION, THE HEALTH MAINTENANCE ORGANIZATION MAY NOT LIMIT THE ENROLLEE TO A HEALTH MAINTENANCE ORGANIZATION PROVIDER FOR THE TREATMENT OF AND APPROPRIATE ANCILLARY SERVICES FOR MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION;

(II) IF AN ENROLLEE CHOOSES A PROVIDER OTHER THAN THE HEALTH MAINTENANCE ORGANIZATION PROVIDER FOR SUCH TREATMENT AND REFERRAL SERVICES, THE ENROLLEE'S DESIGNATED PROVIDER MUST LIMIT HIS TREATMENT AND SERVICES TO THE SCOPE OF THE

REFERRAL IN ORDER TO RECEIVE PAYMENT FROM THE HEALTH MAINTENANCE ORGANIZATION;

(III) THE AMOUNT PAID BY THE HEALTH MAINTENANCE ORGANIZATION TO THE ENROLLEE'S DESIGNATED PROVIDER MAY NOT EXCEED THE AMOUNT PAID BY THE HEALTH MAINTENANCE ORGANIZATION TO ONE OF ITS PROVIDERS FOR EQUIVALENT TREATMENT OR SERVICES;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, his dependents, or family members continuing coverage on the enrollee, his dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, his dependents, or family members covered under the evidence of coverage ceases because of termination of employment or of his membership in the class or classes eligible for coverage under the policy or because his employer discontinues his business or the coverage;

(ii) if the enrollee had been enrolled in the health

maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains

any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or his dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee must not be individually determined based on the status of his health. ~~However,--the--charges--may-not-be-excessive,-inadequate,-or unfairly-discriminatory-and-cannot--be--amended--more--often than--once--in--a--12-month--period--unless--a-more-frequent~~

~~amendment is actuarially justified and necessary to preserve the financial solvency of the health maintenance organization. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the charges, based on reasonable assumptions, must accompany the filing, along with adequate supporting information.~~

(7) The commissioner shall, within ~~a reasonable period~~ 60 DAYS, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form ~~or use a schedule of charges~~ before the commissioner approves the form ~~or the health maintenance organization files the schedule of charges~~. If the commissioner disapproves the filing, he shall notify the filer. In the notice, the commissioner shall specify the reasons for his disapproval. The commissioner shall grant a hearing within 30 days after he receives a written request by the filer.

(8) The commissioner may in his discretion require a health maintenance organization to submit any RELEVANT information he considers necessary in determining whether to approve or disapprove a filing made pursuant to this section.

NEW SECTION. Section 9. Annual statement -- revocation for failure to file -- penalty for perjury. (1)

Each UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN, EACH authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may in his discretion waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in [section 22]. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in [section 22], or may in his discretion suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may, AFTER NOTICE AND HEARING, impose a fine not to exceed $5,000 per violation upon a director, officer, partner, member, agent, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement which is

false.

(4) The commissioner may require such reports as he considers reasonably necessary and appropriate to enable him to carry out his duties under [sections 1 through 29], INCLUDING BUT NOT LIMITED TO A STATEMENT OF OPERATIONS, TRANSACTIONS, AND AFFAIRS OF A HEALTH MAINTENANCE ORGANIZATION OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN.

NEW SECTION. Section 10. Information to enrollees. Each authorized health maintenance organization shall ~~promptly~~ provide to its enrollees ~~notice~~ 30 DAYS' ADVANCE NOTICE IN WRITING of any material change in the operation of the health maintenance organization that will affect them directly.

NEW SECTION. Section 11. Complaint system. (1) (a) Each authorized health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures to resolve written complaints initiated by enrollees. A health maintenance organization may not use a complaint system:

(i) before the commissioner approves it; and

(ii) unless the health maintenance organization describes it in each evidence of coverage issued or delivered to an enrollee in this state.

(b) Each time the health maintenance organization

denies a claim or initiates disenrollment, cancellation, or nonrenewal, it shall notify the affected enrollee of the right to file a complaint and the procedure for filing a complaint.

(c) Each health maintenance organization shall acknowledge a complaint within 10 days of receiving it.

(d) Each health maintenance organization shall retain records of all complaints for 3 years and shall develop a summary for each year that must include:

(i) a description of the procedures of the complaint system;

(ii) the total number of complaints handled through the complaint system, a compilation of causes underlying the complaints filed, the date on which each complaint was filed, the date on which each complaint was resolved, the disposition of each complaint filed, the time it took to process each complaint, and a summary of each administrative change made because of a complaint; and

(iii) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that were settled during the year by the health maintenance organization.

(e) The health maintenance organization shall annually on or before March 1 file with the commissioner the summary described in subsection (1)(d) for the preceding year.

(2) The commissioner shall hold in confidence the information provided by the health maintenance organization pursuant to subsection (1)(d)(iii).

(3) The commissioner may examine a complaint system.

NEW SECTION. Section 12. Investment regulations. A EXCEPT FOR A HEALTH MAINTENANCE ORGANIZATION OPERATED AS A PLAN BY A HEALTH SERVICE CORPORATION, A domestic health maintenance organization may invest its funds only as prescribed in ~~rules-adopted-by-the--commissioner~~ TITLE 33, CHAPTER 2, PART 8.

NEW SECTION. Section 13. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation must be the greater of:

(a) 5% of its estimated expenditures for health care services for its first year of operation;

(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or

(c) $100,000.

(3) At the beginning of each succeeding year, unless

not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on [the effective date of this act] shall make a deposit equal to the greater of:

(a) 1% of the preceding 12 months' uncovered expenditures; or

(b) $100,000 on the first day of the fiscal year beginning 6 months or more after [the effective date of this act]. In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably reflect the preceding year's operating experience and delivery arrangements.

(5) The commissioner may in his discretion waive any of the deposit requirements set forth in subsections (1)

through (4) whenever he is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year;

(b) the health maintenance organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth not including land, buildings, and equipment of at least $1 million or achieves a net worth including organization-related land, buildings, and equipment of at least $5 million the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth not including land,

buildings, and equipment of at least $1 million or that has been in operation for at least 10 years and has a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of such health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not

required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, except that its total deposit may not be required to exceed the maximum required under this section.

(9) ~~Each~~ UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN, EACH health maintenance organization shall have a minimum capital of at least $200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

(a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

(b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical

underwriting or preexisting limitation requirements.

NEW SECTION. Section 14. Prohibited practices. (1) A health maintenance organization, or representative thereof, may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of [sections 1 through 29]:

~~(a)--a-statement-or-item-of-information--is--considered to--be--untrue-if-it-does-not-conform-to-fact-in-any-respect that-is-or-may-be-significant-to-an-enrollee-of,--or--person considering----enrollment----in,----a---health---maintenance organization;~~

~~(b)~~(A) a statement or item of information is considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, a reasonable person, not possessing special knowledge regarding health care coverage, may reasonably understand the statement or item of information as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

~~(c)~~(B) an evidence of coverage is considered to be deceptive if, when taken as a whole and with consideration given to typography, format, and language, it can cause a reasonable person, not possessing special knowledge regarding health maintenance organizations, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage does not regularly make available to enrollees covered under the evidence of coverage.

(2) Title 33, chapter 18, applies to health maintenance organizations and evidences of coverage issued by a health maintenance organization, except to the extent that the commissioner determines that the nature of health maintenance organizations and evidences of coverage render the chapter clearly inappropriate.

(3) A health maintenance organization shall clearly disclose in the evidence of coverage the circumstances under which it may disenroll, cancel, or refuse to renew an enrollee. A health maintenance organization may only disenroll, cancel, or refuse to renew an enrollee if the enrollee:

(a) has failed to pay required premiums by the end of the grace period;

(b) has committed acts of physical or verbal abuse

that pose a threat to providers or other enrollees of the health maintenance organization;

(c) has allowed a nonenrollee to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;

(d) has moved outside of the geographical service area of the health maintenance organization; ~~or~~

(E) HAS VIOLATED RULES OF THE HEALTH MAINTENANCE ORGANIZATION STATED IN THE EVIDENCE OF COVERAGE;

(F) HAS VIOLATED RULES ADOPTED BY THE COMMISSIONER FOR ENROLLMENT IN A HEALTH MAINTENANCE ORGANIZATION; OR

~~(e)~~(G) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that he may file a grievance on this matter.

(4) A health maintenance organization may not disenroll an enrollee under subsection (3) for reasons related to the physical or mental condition of the enrollee

or for any of the following reasons:

(a) failure of the enrollee to follow a prescribed course of treatment; or

(b) administrative actions, such as failure to keep an appointment.

(5) (a) A health maintenance organization that disenrolls a group certificate holder for any reason **except** ~~failure--to--pay--required-premiums~~ NOT LISTED IN SUBSECTION (3) OR PROVIDED IN RULES ADOPTED BY THE COMMISSIONER shall make arrangements to provide similar alternate insurance coverage to enrollees. The insurance coverage must be continued until the disenrolled group certificate holder finds its own coverage or a period of ~~36~~ 12 months elapses, whichever comes first. The premium on the individual coverage must be at the then-customary rate applicable to the individual coverage offered by the insurer, health service corporation, or health maintenance organization that provides the alternate insurance coverage.

(b) If a health maintenance organization disenrolls an enrollee covered on an individual basis for any reason **except--~~failure--to--pay--required--premiums~~** NOT LISTED IN SUBSECTION (3) OR PROVIDED IN RULES ADOPTED BY THE COMMISSIONER, coverage must be continued until the anniversary date of the policy or for 1 year, whichever is earlier. A health maintenance organization that disenrolls

an individual enrollee for failure to pay a required premium or for fraudulent statements on the enrollment form need not provide alternate insurance coverage to that enrollee.

(6) A health maintenance organization may not refer to itself as an insurer unless licensed as an insurer or use a name deceptively similar to the name or description of an insurer authorized to transact insurance in this state.

(7) A person may not refer to itself as a health maintenance organization or HMO unless it holds a valid certificate of authority issued by the commissioner.

NEW SECTION. Section 15. Agent license required -- application, issuance, renewal, fees -- penalty. (1) No individual, partnership, or corporation may act as or hold himself out to be an agent of a health maintenance organization unless he is:

(a) licensed as a disability insurance agent by the commissioner pursuant to chapter 17, parts 1, 2, and 4 of this title OR LICENSED AS AN ENROLLMENT REPRESENTATIVE UNDER 33-30-311 THROUGH 33-30-313; and

(b) appointed or authorized by the health maintenance organization to solicit health care service agreements on its behalf.

(2) Application, appointment and qualification for a health maintenance organization agent license, fees applicable to and the issuance of a health maintenance

organization agent license, and renewal of a health maintenance organization agent license must be in accordance with the provisions of chapter 17 that apply to a disability insurance agent.

(3) An individual, partnership, or corporation who holds a disability insurance agent license on [the effective date of this act] need not requalify by an examination to be licensed as a health maintenance organization agent.

(4) The commissioner may, in accordance with 33-1-313, 33-1-317, 33-17-411, and chapter 17, part 10, suspend, revoke, refuse to issue or renew a health maintenance organization agent license, or impose a fine upon the licensee.

NEW SECTION. Section 16. Powers of insurers and health service corporations. (1) An insurer authorized to transact insurance in this state or a health service corporation authorized to do business in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of [sections 1 through 29]. Notwithstanding any other law which may be inconsistent with this section, two or more insurers, health service corporations, or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance is considered to include the provision of health

care services by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any insurance or health service corporation laws, an insurer or a health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance organization and to provide coverage if the health maintenance organization fails to meet its obligations.

(3) The enrollees of a health maintenance organization constitute a permissible group under this title. The insurer or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers under the contracts described in subsection (2).

(4) Nothing in this section exempts a health maintenance organization that provides health care services from complying with the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 17. Examination. (1) The commissioner may examine the affairs of a health maintenance organization ~~and--the--providers--with--whom---the---health maintenance-organization-has-contracts,-agreements,-or-other arrangements~~ as often as is reasonably necessary to protect the interests of the people of this state. The commissioner

shall make such an examination at least once every 3 years.

(2) The department of health may examine the ~~quality~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY of the health care services provided by any health maintenance organization and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary to protect the interests of the people of this state. The department of health shall make such an examination at least once every 3 years.

(3) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner and the department of health may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.

(4) (a) (i) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or

adopted by the commissioner. The commissioner may present such an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any such examination.

(ii) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (4)(a)(i), the commissioner shall pay them out of the funds of the commissioner in the same manner as other disbursements of such funds. The amount so paid must be a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund.

(b) The expenses of examination conducted by the director under this section must be assessed against the health maintenance organization and remitted to the director. Such remitted expenses are statutorily appropriated to the department of health as provided in 17-7-502.

(5) In lieu of an examination, the commissioner or the director may accept the report of an examination made by the commissioner or the director of another state.

NEW SECTION. Section 18. Suspension or revocation of

certificate of authority. (1) The commissioner may in his discretion suspend or revoke any certificate of authority issued to a health maintenance organization under [sections 1 through 29] if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under [section 3] AND PROVIDED THAT SUCH OPERATION ADVERSELY AFFECTS THE HEALTH MAINTENANCE ORGANIZATION'S ABILITY TO PROVIDE BENEFITS AND OPERATE UNDER THE APPLICATION APPROVED BY THE COMMISSIONER, unless amendments to such submissions have been filed with and approved by the commissioner.

(b) The health maintenance organization issues evidences of coverage or uses a schedule of charges for health care services that do not comply with the requirements of [section 8].

(c) The health maintenance organization does not provide or arrange for basic health care services.

(d) The director, AFTER NOTICE AND HEARING, certifies to the commissioner that:

(i) the health maintenance organization does not meet the requirements of [section 4(1)]; or

(ii) the health maintenance organization is unable to

fulfill its obligations to furnish health care services.

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under [section 6].

(g) The health maintenance organization has failed to implement the complaint system required by [section 11] to resolve valid complaints in a reasonable manner.

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(j) The health maintenance organization has otherwise failed to substantially comply with [sections 1 through 29].

(2) The commissioner may in his discretion suspend or revoke a certificate of authority only if he complies with the requirements of [section 21].

(3) When the certificate of authority of a health maintenance organization is suspended, the health

maintenance organization may not, during the period of such suspension, enroll any additional enrollees except newborn infants or other newly acquired dependents of existing enrollees and may not engage in any advertising or solicitation.

(4) If the commissioner revokes the certificate of authority of a health maintenance organization, the health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may not transact further business except as may be essential to the orderly conclusion of its affairs. It may not engage in further advertising or solicitation following the effective date of the order of revocation. The commissioner may by written order permit further operation of the health maintenance organization if he finds further operation to be in the best interest of enrollees to the extent that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

NEW SECTION. Section 19. Supervision, rehabilitation, or liquidation of a health maintenance organization. (1) The supervision, rehabilitation, or liquidation of a health maintenance organization is considered to be the supervision, rehabilitation, or liquidation of an insurer and must be conducted under the supervision of the

commissioner pursuant to chapter 2, part 13. The commissioner may apply for an order directing him to supervise, rehabilitate, or liquidate a health maintenance organization upon any one or more grounds set out in 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as a claim by an enrollee if the provider of services agrees not to assert the claim against any enrollee of the health maintenance organization.

NEW SECTION. Section 20. Rules. (1) The commissioner may, after notice and hearing, make reasonable rules necessary to effectuate [sections 1 through 29].

(2) The department of health may make reasonable rules necessary to effectuate [sections 1 through 29].

NEW SECTION. Section 21. Administrative procedures. (1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist or that grounds for the suspension or revocation of a certificate of authority exist, he shall give written notice to the health maintenance organization

and the department of health specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days after the notice for a hearing on the matter.

(2) The director or his designated representative may attend the hearing and may participate in the proceeding. The recommendations and findings of the director with respect to matters relating to the ~~quality~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority must be conclusive and binding upon the commissioner. After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall make written findings and act as he considers advisable. The commissioner shall mail the written findings to the health maintenance organization and submit a copy to the director. The action of the commissioner and the recommendations and findings of the director are subject to review by the district court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

(3) ~~The-Montana-Administrative-Procedure-Act,-Title-2,-chapter-4,-applies-to-proceedings-under-this-section-to--the-extent-it-is-not-in-conflict-with-this-section.~~ WHERE NOTICE

AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE COMMISSIONER UNDER [SECTIONS 1 THROUGH 29], THE REQUIREMENTS OF 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, APPLY, EXCEPT THAT THE FORMAL RULES OF PLEADING AND EVIDENCE MUST BE OBSERVED. TO THE EXTENT THAT 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, DO NOT ADDRESS THE NOTICE AND HEARING REQUIREMENTS OF [SECTIONS 1 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7, APPLY.

(4) WHERE NOTICE AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE DIRECTOR UNDER [SECTIONS 1 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7, APPLY.

NEW SECTION. Section 22. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

(a) for filing an application for a certificate of authority or amendment thereto, $300;

(b) for filing an amendment to the organization documents that requires approval, $25;

(c) for filing each annual statement, $25;

(D) FOR ANNUAL CONTINUATION OF CERTIFICATE OF AUTHORITY, $300.

(2) All fees and miscellaneous charges, except fines or penalties or those amounts received pursuant to [sections

9(3) and 23], collected by the commissioner pursuant to [sections 1 through 29] and the rules adopted thereunder must be deposited in the insurance regulatory trust account pursuant to 17-2-121 through 17-2-123.

(3) The director may assess fees necessary and adequate to cover the expenses of the director's functions~~, other--than--examinations,~~ under this chapter. ~~Such-fees-are statutorily-appropriated-to--the--department--of--health--as provided--in--17-7-502. THESE-FEES-MUST-BE-DEPOSITED-IN-THE GENERAL-FUND.~~ SUCH FEES ARE STATUTORILY APPROPRIATED TO THE DEPARTMENT OF HEALTH AS PROVIDED IN 17-7-502.

NEW SECTION. Section 23. Penalties and enforcement. (1) The commissioner may, in addition to suspension or revocation of a certificate of authority under [section 18], AFTER NOTICE AND HEARING, impose an administrative penalty in an amount not less than $500 or more than $10,000 if he gives reasonable notice in writing of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation. ~~The commissioner-may-augment-this-penalty-by-an-amount-equal--to the--sum--that--he--calculates-to-be-the-damages-suffered-by enrollees-or-other-members-of-the-public.~~

(2) ~~(a)~~ If the commissioner or the director has cause to believe that a violation of [sections 1 through 29] has

occurred or is threatened, the commissioner or the director may:

~~(ii)~~(A) give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation;

~~(iii)~~(B) arrange a conference with the alleged violators or their authorized representatives to attempt to ascertain the facts relating to the suspected violation; and

~~(iv)~~(C) if it appears that a violation has occurred or is threatened, arrive at an adequate and effective means of correcting or preventing the violation.

~~(b) Proceedings under this subsection are not governed by any formal procedural requirements and may be conducted in a manner the commissioner or the director considers appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of [section 21] or this section are satisfied.~~

(3) (a) The commissioner may issue an order directing a health maintenance organization or its representative to cease and desist from engaging in an act or practice in violation of [sections 1 through 29].

(b) Within 15 days after service of the cease and desist order, the respondent may request a hearing to determine whether acts or practices in violation of

[sections 1 through 29] have occurred. The hearing must be conducted pursuant to Title 2, chapter 4, part 6, and judicial review must be available as provided by Title 2, chapter 4, part 7.

(4) If a health maintenance organization violates a provision of [sections 1 through 29] and the commissioner elects not to issue a cease and desist order or if the respondent does not comply with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lewis and Clark County.

NEW SECTION. Section 24. Statutory construction and relationship to other laws. (1) Except as otherwise provided in [sections 1 through 29], the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under [sections 1 through 29]. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to [sections 1 through 29].

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its

representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under [sections 1 through 29] may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of [sections 1 through 29] do not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 25. Filings and reports as public documents. All applications, filings, and reports required under [sections 1 through 29], except those that contain trade secrets or privileged or confidential commercial or financial information (other than an annual financial statement that the commissioner may require under [section 9]), are public documents.

NEW SECTION. Section 26. Confidentiality of medical information. (1) Any data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant obtained from the enrollee, applicant, or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except:

(a) to the extent that it may be necessary to carry

out the purposes of [sections 1 through 29];

(b) upon the express consent of the enrollee or applicant;

(c) pursuant to statute or court order for the production of evidence or the discovery thereof; or

(d) in the event of claim or litigation between the enrollee or applicant and the health maintenance organization wherein the data or information is pertinent.

(2) A health maintenance organization is entitled to claim the same statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

NEW SECTION. Section 27. Authority of director to contract. The director in carrying out his obligations under [sections 4(1), 17(2), and 18(1)] may contract with qualified persons to make recommendations concerning the determinations he is required to make. The contractors' recommendations may be accepted OR REJECTED in full or in part by the director.

NEW SECTION. Section 28. Acquisition, control, or merger of a health maintenance organization. (1) Except as provided in 33-2-1106 and subsection (2), no person may tender for, request, or invite tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health

maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization.

(2) No person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the acquiring person has filed with the commissioner and has sent to the health maintenance organization information required by 33-2-1104(2) and the commissioner has approved the offer, request, invitation, agreement, or acquisition pursuant to 33-2-1105.

NEW SECTION. Section 29. Dual choice. ~~(1)-Each-public-or-private-employer-in-this-state-that-employs-not-less-than-25--employees-and-offers-its-employees-a-health-benefit-plan-and-each-employee-benefit-fund-in-this-state-that-offers-its-members-any-form-of-disability-insurance-benefit-shall--make-available--to--and--inform--its--employees-or-members-of-the-option--to--enroll--in--at--least--one--health---maintenance-organization--holding--a-valid-certificate-of-authority-that-provides-health-care-services-in--the--geographic--areas--in~~

~~which--a--substantial--number--of--the--employees-or-members reside.--If--there--is--a--prevailing--collective--bargaining agreement,---the---selection---of---the--health--maintenance organization-to-be-made-available-to-the-employees--must--be made-pursuant-to-the-agreement.~~

~~(2)~~ An employer in this state THAT OFFERS ITS EMPLOYEES THE OPTION TO ENROLL IN A HEALTH MAINTENANCE ORGANIZATION AND AN EMPLOYEE BENEFIT FUND IN THIS STATE THAT OFFERS ITS MEMBERS THE OPTION TO ENROLL IN A HEALTH MAINTENANCE ORGANIZATION may not be required to pay more for health benefits ~~as-a--result--of--the--application--of--this section~~ PROVIDED BY THE HEALTH MAINTENANCE ORGANIZATION than it would otherwise be required to provide by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, if the employer or benefits fund pays to the health maintenance organization chosen by each employee or member an amount equal to the lesser of:

~~(a)~~(1) the amount paid on behalf of its other employees or members of health benefits; or

~~(b)~~(2) the health maintenance organization's charge for coverage approved by the commissioner pursuant to [section 8].

~~Section-30.--Section--33-22-111,--MCA,--is--amended--to read.~~

"33-22-111.--Policies-to-provide-for-freedom-of--choice of-practitioners----professional-practice-not-enlarged.--(1) All Except--as--provided--in--[sections--1-through-29],-all policies--of--disability--insurance,--including--individual, group,--and--blanket-policies,-and-all-policies-insuring-the payment-of-compensation-under-the-Workers'-Compensation--Act shall--provide-the-insured-shall-have-full-freedom-of-choice in-the-selection-of-any-duly--licensed--physician,--dentist, osteopath,-----chiropractor,----optometrist,----chiropodist, psychologist,-licensed-social-worker,-or-nurse-specialist-as specifically-listed-in-37-8-202-for-treatment-of-any-illness or-injury-within-the-scope-and-limitations-of-his--practice. Whenever--such-policies-insure-against-the-expense-of-drugs, the-insured--shall--have--full--freedom--of--choice--in--the selection--of--any--duly-licensed-and-registered-pharmacist. An-insurer-shall-offer,-at-additional-cost-to--the--insured, the--option--of-disability-and-health-insurance-coverage-for services-performed-by-a-licensed-professional-counselor.

(2)--Nothing-in-this--section--shall--be--construed--as enlarging--the--scope--and-limitations-of-practice-of-any-of the-licensed-professions-enumerated-in-subsection--(1),--nor shall--this--section--be-construed-as-amending,-altering,-or repealing-any-statutes-relating-to-the-licensing-or--use--of hospitals."

Section-31.--Section-17-7-502,-MCA,-is-amended-to-read:

~~"17-7-502.--Statutory--appropriations-----definition---requisites-for-validity.--(1)-A-statutory--appropriation--is an--appropriation--made--by--permanent--law--that-authorizes spending-by-a-state-agency-without-the-need-for--a--biennial legislative-appropriation-or-budget-amendment.~~

~~(2)--Except--as--provided--in--subsection--(4),--to--be effective,-a-statutory-appropriation-must-comply--with--both of-the-following-provisions:~~

~~(a)--The-law-containing-the-statutory-authority-must-be listed-in-subsection-(3).~~

~~(b)--The--law--or-portion-of-the-law-making-a-statutory appropriation--must--specifically--state--that--a--statutory appropriation-is-made-as-provided-in-this-section.~~

~~(3)--The--following--laws--are-the-only-laws-containing statutory-appropriations:~~

~~(a)--2-9-202;~~

~~(b)--2-17-105;~~

~~(c)--2-18-812;~~

~~(d)--10-3-203;~~

~~(e)--10-3-312;~~

~~(f)--10-3-314;~~

~~(g)--10-4-301;~~

~~(h)--13-37-304;~~

~~(i)--15-31-702;~~

~~(j)--15-36-112;~~

{k}--15-70-101;

{l}--16-1-404;

{m}--16-1-410;

{n}--16-1-411;

{o}--17-3-212;

{p}--17-5-404;

{q}--17-5-424;

{r}--17-5-804;

{s}--19-8-504;

{t}--19-9-702;

{u}--19-9-1007;

{v}--19-10-205;

{w}--19-10-305;

{x}--19-10-506;

{y}--19-11-512;

{z}--19-11-513;

{aa}-19-11-606;

{bb}-19-12-301;

{cc}-19-13-604;

{dd}-20-6-406;

{ee}-20-8-111;

{ff}-23-5-612;

{gg}-{section-17};

{hh}-{section-22};

{gg}{ii}-37-51-501;

~~(hh)~~ (jjj) ~~53-24-206;~~

~~(ii)~~ (kk) ~~75-1-1101;~~

~~(jj)~~ (lll) ~~75-7-305;~~

~~(kk)~~ (mm) ~~80-2-103;~~

~~(ll)~~ (nn) ~~80-2-228;~~

~~(mm)~~ (oo) ~~90-3-3011;~~

~~(nn)~~ (pp) ~~90-3-302;~~

~~(oo)~~ (qq) ~~90-15-103;~~ ~~and~~

~~(pp)~~ (rr) ~~Sec. 13, HB 861, L. 1985.~~

~~(4) --There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. ---Agencies---that---have--entered--into--agreements authorized--by--the--laws--of--Montana--to--pay--the---state treasurer,--for--deposit-in-accordance-with-17-2-101-through 17-2-107,-as-determined-by-the-state--treasurer,--an--amount sufficient--to--pay-the-principal-and-interest-as-due-on-the bonds-or-notes-have-statutory--appropriation--authority--for such-payments.~~"

SECTION 30. SECTION 17-7-502, MCA, IS AMENDED TO READ:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial

legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;

(b) 2-17-105;

(c) 2-18-812;

(d) 10-3-203;

(e) 10-3-312;

(f) 10-3-314;

(g) 10-4-301;

(h) 13-37-304;

(i) 15-31-702;

(j) 15-36-112;

(k) 15-70-101;

(l) 16-1-404;

(m) 16-1-410;

(n) 16-1-411;

(o) 17-3-212;

(p) 17-5-404;

(q) 17-5-424;

(r) 17-5-804;

(s) 19-8-504;

(t) 19-9-702;

(u) 19-9-1007;

(v) 19-10-205;

(w) 19-10-305;

(x) 19-10-506;

(y) 19-11-512;

(z) 19-11-513;

(aa) 19-11-606;

(bb) 19-12-301;

(cc) 19-13-604;

(dd) 20-6-406;

(ee) 20-8-111;

(ff) 23-5-612;

(gg) [section 17];

(hh) [section 22];

~~(gg)~~(ii) 37-51-501;

~~(hh)~~(jj) 53-24-206;

~~(ii)~~(kk) 75-1-1101;

~~(jj)~~(ll) 75-7-305;

~~(kk)~~(mm) 80-2-103;

~~(ll)~~ (nn) 80-2-228;

~~(mm)~~ (oo) 90-3-301;

~~(nn)~~ (pp) 90-3-302;

~~(oo)~~ (qq) 90-15-103; and

~~(pp)~~ (rr) Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments."

SECTION 31. SECTION 33-1-102, MCA, IS AMENDED TO READ:

"33-1-102. Compliance required -- exceptions -- health service corporations. (1) No person shall transact a business of insurance in Montana or relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) No provision of this code shall apply with respect to:

(a) domestic farm mutual insurers as identified in

chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code shall not apply to health service corporations to the extent that the existence and operations of such corporations are authorized by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and operations of such organizations are authorized by [sections 1 through 29]."

SECTION 32. SECTION 33-1-704, MCA, IS AMENDED TO READ:

"33-1-704. Hearing procedure. (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) ~~Formal~~ Except as provided in [section 21], rules of pleading or evidence need not be observed at any hearing.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

NEW SECTION. Section 33. Codification instruction. Sections 1 through 29 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through 29.

NEW SECTION. Section 34. Severability. If a part of

this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 35. Effective date -- applicability. ~~This--act-is~~ SECTION 20 AND THIS SECTION ARE effective on passage and approval ~~and~~. THIS ACT applies to health maintenance organizations formed before or after the effective date of this act.

-End-

STANDING COMMITTEE REPORT

HOUSE

MARCH 26 19 87

Mr. Speaker: We, the committee on BUSINESS AND LABOR

report SENATE BILL NO. 353

[ ] do pass [X] be concurred in [X] as amended
[ ] do not pass [ ] be not concurred in [ ] statement of intent attached

REP. LES KITSELMAN Chairman

AMENDMENTS AS FOLLOWS:

1) Title, line 7
Following: "33-22-111"
Insert: "17-7-502,"

2) Page 10, line 18
Strike: "for approval"

3) Page 10, line 19
Following: "[section 8(7)]"
Insert: ", however, nothing in this subsection deprives the health maintenance organization of its right to confidentiality of any proprietary information and the commissioner may not disclose that proprietary information to any other person"

4) Page 13, line 1
Following: Page 12, line 25
Insert: "(7) The commissioner may make reasonable rules exempting an insurer or health service corporation operating a health maintenance organization as a plan from the filing requirements of this section if information requested in the application has been submitted to the commissioner under other laws and rules administered by the commissioner."

5) Page 18, line 3
Following: "may"
Insert: ", after notice and hearing, within 60 days."

6) Page 18, line 4
Following: "power"
Insert: "under subsection (1)(a), (1)(b), or (1)(d)"

7) Page 18, lines 10, 11, and 12
Strike: lines 10 and 11 in their entirety and line 12 through "commissioner."

REP. KITSELMAN will sponsor

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8) Page 20, lines 18 and 19
Following: "is" on line 18
Strike: the remainder of line 18 and line 19 in its entirety

9) Page 23, line 1
Following: "limits"
Insert: "and coverage"

10) Page 23, line 2
Strike: "33-22-703;"
Insert: "Title 33, chapter 22, part 7, however, after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction.
(i) If an enrollee chooses a provider other than the health maintenance organization provider for such treatment and referral services, the enrollee's designated provider must limit his treatment and services to the scope of the referral in order to receive payment from the health maintenance organization.
(ii) The amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services."

11) Page 25, line 18, through page 26, line 2
Following: Page 25, line 17
Strike: lines 18 through 25 on page 25 and lines 1 and 2 on page 26 in their entirety

12) Page 26, lines 3 and 4
Strike: "a reasonable period"
Insert: "60 days"

13) Page 26, line 6
Strike: "or use a schedule of charges"

14) Page 26, lines 7 and 8
Following: "form" on line 7
Strike: the remainder of line 7 and line 8 through "charges."

Chairman.

15) Page 26, line 15
Following: "any"
Insert: "relevant"

16) Page 29, line 24
Strike: "A"
Insert: "Except for a health maintenance organization operated as a plan by a health service corporation, a"
17) Page 39, line 10
Following: "title"
Insert: "or licensed as an enrollment representative under 33-30-311 through 33-30-313"

18) Page 41, lines 13 through 15
Following: "organization" on line 13
Strike: the remainder of line 13, line 14 in its entirety and line 15 through "arrangements"

19) Page 43, line 25
Following: "[section3]
Insert: "and provided that such operation adversely affects the health maintenance organization's ability to provide benefits and operate under the application approved by the commissioner"

20) Page 47, line 21
Strike: "quality"
Insert: "availability, accessibility, and continuity"

21) Page 49, line 9
Following: "$25"
Insert: ";
(d) for annual continuation of certificate of authority, $300"

22) Page 49, lines 20 and 21
Following : "~~17-7-502.~~" on line 20
Strike: the remainder of line 20 and line 21 in its entirety
Insert: "Such fees are statutorily appropriated to the department of health as provided in 17-7-502."

23) Page 60, line 6
Following: line 5
Insert: "Section 30. Section 17-7-502, MCA, is amended to read:

Chairman.

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.
(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:
(a) The law containing the statutory authority must be listed in subsection (3).
(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.
(3) The following laws are the only laws containing statutory appropriations:
(a) 2-9-202;
(b) 2-17-105;
(c) 2-18-812;
(d) 10-3-203;
(e) 10-3-312;
(f) 10-3-314;
(g) 10-4-301;
(h) 13-37-304;
(i) 15-31-702;
(j) 15-36-112;
(k) 15-70-101;
(l) 16-1-404;
(m) 16-1-410;
(n) 16-1-411;
(o) 17-3-212;
(p) 17-5-404;
(q) 17-5-424;
(r) 17-5-804;
(s) 19-8-504;
(t) 19-9-702
(u) 19-9-1007;
(v) 19-10-205;
(w) 19-10-305,
(x) 19-10-506;
(y) 19-11-512;
(z) 19-11-513;
(aa) 19-11-606;
(bb) 19-12-301;
(cc) 19-13-604;
(dd) 20-6-406;

Chairman

(ee) 20-8-111;
(ff) 23-5-612;
(gg) [section 17];
(hh) [section 22];
(ii) 37-51-501;
(jj) 53-24-206;
(kk) 75-1-1101;
(ll) 75-7-305;
(mm) 80-2-103;
(nn) 80-2-228;
(oo) 90-3-301;
(pp) 90-3-302;
(qq) 90-15-103; and
(rr) Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments."

Renumber: subsequent sections

Chairman

STATEMENT OF INTENT

SB 353 - BLUE COPY

AMENDMENTS AS FOLLOWS:

1) Page 2

Strike: lines 9 through 14 in their entirety

Insert: "Any rule promulgated by the commissioner in regard to advisory boards of health maintenance organizations must require the membership of those advisory boards to multidisciplinary representatives."

Chairman

STATEMENT OF INTENT

SENATE BILL 353

Senate Public Health, Welfare, and Safety Committee

A statement of intent is required for this bill because:

(1) it authorizes the commissioner of insurance of the state of Montana (commissioner) and the department of health and environmental sciences to adopt, after notice and hearing, reasonable rules necessary or proper to effectuate sections 1 through 29;

(2) section 3 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner describing material modifications of information required in an application for a certificate of authority if the commissioner considers the information unnecessary; and

(3) section 5 authorizes the commissioner to make reasonable rules exempting a health maintenance organization from having to file a notice with the commissioner before exercising the powers granted in subsection (1)(a), (1)(b), or (1)(d) if the commissioner believes exercising those powers will have de minimis effect. The legislature expects the commissioner to make only reasonable rules necessary to effectuate or aid the effectuation of sections 1 through 29.

The legislature does not authorize the commissioner to adopt rules that extend, modify, or conflict with either any law of this state or any reasonable implications of those laws. If reasonably possible, the commissioner shall set forth a proposed rule or amendment to a rule in or with the required notice of hearing. No rule or amendment to a rule by the commissioner is effective until it has been on file in the commissioner's office for at least 10 days.

~~In adopting rules prescribing investment regulations, the commissioner shall use the NAIC Model Health Maintenance Organization Investment Guidelines.~~

~~The commissioner and the department are urged to look to regulations adopted by the state of Minnesota in implementing chapter 62D of the Minnesota insurance code.~~

ANY RULE PROMULGATED BY THE COMMISSIONER IN REGARD TO ADVISORY BOARDS OF HEALTH MAINTENANCE ORGANIZATIONS MUST REQUIRE THE MEMBERSHIP OF THOSE ADVISORY BOARDS TO INCLUDE MULTIDISCIPLINARY REPRESENTATIVES.

REFERENCE BILL
SB 353

SENATE BILL NO. 353

INTRODUCED BY MEYER, LORY, BENGTSON, MILLER, MCLANE, SANDS

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT TO REGULATE THE FORMATION AND OPERATION OF HEALTH MAINTENANCE ORGANIZATIONS; AMENDING SECTIONS ~~17-7-502 AND 33-22-111~~ 17-7-502, 33-1-102, AND 33-1-704, MCA; AND PROVIDING AN ~~IMMEDIATE~~ EFFECTIVE DATE AND AN APPLICABILITY PROVISION."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. Section 1. Short title. This act may be cited as the "Montana Health Maintenance Organization Act".

NEW SECTION. Section 2. Definitions. As used in [sections 1 through 29], unless the context requires otherwise, the following definitions apply:

(1) "Agent" means an individual, partnership, or corporation appointed or authorized by a health maintenance organization to solicit applications for health care services agreements on its behalf.

(2) "Basic health care services" means:

(a) consultative, diagnostic, therapeutic, and referral services by a provider;

(b) inpatient hospital and provider care;

(c) outpatient medical services;

(d) medical treatment and referral services;

(e) accident and sickness services by a provider to each newborn infant of an enrollee pursuant to [section 8(3)(e)];

(F) CARE AND TREATMENT OF MENTAL ILLNESS, ALCOHOLISM, AND DRUG ADDICTION;

~~(f)~~(G) diagnostic laboratory and diagnostic and therapeutic radiologic services; and

~~(g)~~(H) preventive health services, including:

(i) immunizations;

(ii) well-child care from birth;

(iii) periodic health evaluations for adults;

(iv) voluntary family planning services;

(v) infertility services; and

(vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction.

(3) "Commissioner" means the commissioner of insurance of the state of Montana.

(4) "Department of health" means the department of health and environmental sciences provided for in 2-15-2101.

(5) "Director" means the director of the department of health and environmental sciences provided for in 2-15-2102.

(6) "Enrollee" means a person:

(a) who enrolls in or contracts with a health maintenance organization;

(b) on whose behalf a contract is made with a health maintenance organization to receive health care services; or

(c) on whose behalf the health maintenance organization contracts to receive health care services.

(7) "Evidence of coverage" means a certificate, agreement, policy, or contract issued to an enrollee setting forth the coverage to which the enrollee is entitled.

(8) "Health care services" means:

(a) the services included in furnishing medical or dental care to a person;

(b) the services included in hospitalizing a person;

(c) the services incident to furnishing medical or dental care or hospitalization; or

(d) the services included in furnishing to a person other services for the purpose of preventing, alleviating, curing, or healing illness, injury, or physical disability.

(9) "Health care services agreement" means an agreement for health care services between a health maintenance organization and an enrollee.

(10) "Health maintenance organization" means a person who provides or arranges for basic health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or a group of providers.

(11) "Person" means:

(a) an individual;

(b) a group of individuals;

(c) an insurer, as defined in 33-1-201;

(d) a health service corporation, as defined in 33-30-101;

(e) a corporation, partnership, facility, association, or trust; or

(f) an institution of a governmental unit of any state licensed by that state to provide health care, including but not limited to a physician, hospital, hospital-related facility, or long-term care facility.

(12) "PLAN" MEANS A HEALTH MAINTENANCE ORGANIZATION OPERATED BY AN INSURER OR HEALTH SERVICE CORPORATION AS AN INTEGRAL PART OF THE CORPORATION AND NOT AS A SUBSIDIARY.

~~(12)~~(13) "Provider" means a physician, hospital, hospital-related facility, long-term care facility, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, registered pharmacist, or nurse specialist as specifically listed in 37-8-202 who treats any illness or injury within the scope and limitations of his practice or other person who is licensed or otherwise authorized in this state to furnish health care services.

~~(13)~~(14) "Uncovered expenditures" mean the costs of

health care services that are covered by a health maintenance organization and for which an enrollee is liable if the health maintenance organization becomes insolvent.

NEW SECTION. Section 3. Establishment of health maintenance organizations. (1) Notwithstanding any law of this state to the contrary, a person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with [sections 1 through 29]. A person may not establish or operate a health maintenance organization in this state except as authorized by a subsisting certificate of authority issued to it by the commissioner. A foreign person may qualify for a certificate of authority if it first obtains from the secretary of state a certificate of authority to transact business in this state as a foreign corporation under 35-1-1001.

(2) Each health maintenance organization operating in this state as of [the effective date of this act] shall submit an application for a certificate of authority under subsection (3) within 30 days ~~of [the effective date of this act]~~ AFTER THE EFFECTIVE DATE OF RULES ADOPTED BY THE COMMISSIONER AND THE DEPARTMENT OF HEALTH AS PROVIDED IN [SECTION 20]. Each such applicant may continue to operate in this state until the commissioner acts upon the application. If an application is denied under [section 4], the applicant

must be treated as a health maintenance organization whose certificate of authority has been revoked.

(3) Each application of a health maintenance organization, whether separately licensed or not, for a certificate of authority must:

(a) be verified by an officer or authorized representative of the applicant;

(b) be in a form prescribed by the commissioner;

(c) contain:

(i) the applicant's name;

(ii) the location of the applicant's home office or principal office in the United States (if a foreign person);

(iii) the date of organization or incorporation;

(iv) the form of organization (including whether the providers affiliated with the health maintenance organization will be salaried employees or group or individual contractors);

(v) the state or country of domicile; and

(vi) any additional information the commissioner may reasonably require; and

(d) set forth the following information or be accompanied by the following documents, as applicable:

(i) a copy of the applicant's organizational documents, such as its corporate charters or articles of incorporation, articles of association, partnership

agreement, trust agreement, or other applicable documents, and all amendments thereto, certified by the public officer with whom the originals were filed in the state or country of domicile;

(ii) a copy of the bylaws, rules, and regulations, or similar document, if any, regulating the conduct of the applicant's internal affairs, certified by its secretary or other officer having custody thereof;

(iii) a list of the names, addresses, and official positions of the persons responsible for the conduct of the applicant's affairs, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation; and the partners or members in the case of a partnership or association;

(iv) a copy of any contract made or to be made between:

(A) any provider and the applicant; or

(B) any person listed in subsection (3)(d)(iii) and the applicant. The applicant may file a list of providers executing a standard contract and a copy of the contract instead of copies of each executed contract.

(v) the extent to which any of the following will be included in provider contracts and the form of any provisions that:

(A) limit a provider's ability to seek reimbursement

for basic health care services or health care services from an enrollee;

(B) permit or require a provider to assume a financial risk in the health maintenance organization, including any provisions for assessing the provider, adjusting capitation or fee-for-service rates, or sharing in the earnings or losses; and

(C) govern amending or terminating an agreement with a provider;

(vi) a financial statement showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of [sections 1 through 29].

(vii) a description of the proposed method of marketing, a financial plan that includes a projection of operating results anticipated until the organization has had net income for at least 1 year, and a statement as to the sources of working capital as well as any other source of funding;

~~(viii) a summary of feasibility studies or marketing surveys that support the financial and enrollment~~

~~projections--for-the-plan,-including-the-potential-number-of enrollees-in-the-operating-territory,-the--projected--number of--enrollees--for--the--first--5--years,--the--underwriting standards-to-be-applied,-and-the--method--of--marketing--the organization;~~

~~(ix)~~(VIII) a power of attorney executed by the applicant, on a form prescribed by the commissioner, appointing the commissioner, his successors in office, and his authorized deputies as the applicant's attorney to receive service of legal process issued against it in this state;

~~(x)~~(IX) a statement reasonably describing the geographic service area or areas to be served by county, including:

(A) a chart showing the number of primary and specialty care providers with locations and service areas by county;

(B) the method of handling emergency care, with the location of each emergency care facility; and

(C) the method of handling out-of-area services;

~~(xi)~~(X) a description of the way in which the health maintenance organization provides services to enrollees in each geographic service area, including the extent to which a provider under contract with the health maintenance organization provides primary care to those enrollees;

~~(xii)~~(XI) a description of the complaint procedures to be used as required under [section 11];

~~(xiii)~~(XII) a description of the procedures and programs to be implemented to meet the quality of health care requirements in [section 4];

~~(xiv)~~(XIII) a description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under [section 6];

~~(xv)~~(XIV) a summary of the way in which administrative services will be provided, including the size and qualifications of the administrative staff and the projected cost of administration in relation to premium income. If the health maintenance organization delegates management authority for a major corporate function to a person outside the organization, the health maintenance organization shall include a copy of the contract in its application for a certificate of authority. Contracts for delegated management authority must be filed ~~for approval~~ with the commissioner in accordance with the filing provisions of [section 8(7)], HOWEVER, NOTHING IN THIS SUBSECTION DEPRIVES THE HEALTH MAINTENANCE ORGANIZATION OF ITS RIGHT TO CONFIDENTIALITY OF ANY PROPRIETARY INFORMATION, AND THE COMMISSIONER MAY NOT DISCLOSE THAT PROPRIETARY INFORMATION TO ANY OTHER PERSON. All contracts must include:

(A) the services to be provided;

(B) the standards of performance for the manager;

(C) the method of payment, including any provisions for the administrator to participate in the profits or losses of the plan;

(D) the duration of the contract; and

(E) any provisions for modifying, terminating, or renewing the contract.

~~(xvi) a summary of current and projected enrollment, income from premiums by type of payer, other income, administrative and other costs, the projected break-even point (including the method of finding the recommended losses until the break-even point is reached), and the assumptions made in developing projected operating results;~~

(XV) a summary of all financial guaranties by providers, sponsors, affiliates, or parents within a holding company system or any other guaranties that are intended to ensure the financial success of the plan, including hold harmless agreements by providers, insolvency insurance, reinsurance, or other guaranties;

~~(xviii)~~(XVI) a summary of benefits to be offered enrollees, including any limitations and exclusions and the renewability of all contracts to be written;

~~(xix)~~(XVII) evidence that it can meet the requirement of [section 13(10)]; and

~~(xx)~~(XVIII) any other information that the commissioner

may reasonably require to make the determinations required in [section 4].

(4) Each health maintenance organization shall file each substantial change, alteration, or amendment to the information submitted under subsection (3) with the commissioner at least 30 days prior to its effective date, including changes in articles of incorporation and bylaws, organization type, geographic service area, provider contracts, provider availability, plan administration, financial projections and guaranties, and any other change that might affect the financial solvency of the plan. The commissioner may, AFTER NOTICE AND HEARING, disapprove any proposed change, alteration, or amendment to the business plan. The commissioner may make reasonable rules exempting from the filing requirements of this subsection those that he considers unnecessary.

(5) An applicant or a health maintenance organization holding a certificate of authority shall file with the commissioner all contracts of reinsurance and any modifications thereto. An agreement between a health maintenance organization and an insurer is subject to Title 33, chapter 2, part 12. A reinsurance agreement must remain in full force and effect for at least 90 days following written notice of cancellation by either party by certified mail to the commissioner.

(6) Each health maintenance organization shall maintain, at its administrative office, and make available to the commissioner upon request executed copies of all provider contracts.

(7) THE COMMISSIONER MAY MAKE REASONABLE RULES EXEMPTING AN INSURER OR HEALTH SERVICE CORPORATION OPERATING A HEALTH MAINTENANCE ORGANIZATION AS A PLAN FROM THE FILING REQUIREMENTS OF THIS SECTION IF INFORMATION REQUESTED IN THE APPLICATION HAS BEEN SUBMITTED TO THE COMMISSIONER UNDER OTHER LAWS AND RULES ADMINISTERED BY THE COMMISSIONER.

NEW SECTION. Section 4. Issuance of certificate of authority. (1) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall transmit copies of the application and accompanying documents to the department of health. The department of health shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished, has:

(a) demonstrated the willingness and potential ability to assure that it will provide health care services in a manner assuring availability and accessibility of adequate personnel and facilities and enhancing availability, accessibility, and continuity of service;

(b) arrangements, established in accordance with the rules made by the department of health, for an ongoing

quality assurance program concerning health care **processes and--outcomes** AVAILABILITY, ACCESSIBILITY, AND CONTINUITY OF SERVICE; and

(c) a procedure, established in accordance with rules of the department of health, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and any other matters as may be reasonably required by the department of health.

(2) Within 90 60 days of receipt of the application from a health maintenance organization for issuance of a certificate of authority, the department of health shall certify to the commissioner that the proposed health maintenance organization meets the requirements of subsection (1) or shall, AFTER NOTICE AND HEARING, notify the commissioner that the health maintenance organization does not meet those requirements and specify in what respects it is deficient. The director may extend by not more than an additional 30 days the period within which he may certify to the commissioner that the proposed health maintenance organization meets or does not meet the requirements of subsection (1) by giving notice of the extension to the commissioner and the health maintenance organization before the expiration of the initial **90-day**

60-DAY period.

(3) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to [section 3] within 180 days of receipt of the certification from the department of health. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in [section 22] if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent~~,-trustworthy,-and-of--good reputation~~ AND TRUSTWORTHY.

(b) The department of health certifies, in accordance with subsection (2), that the health maintenance organization's proposed plan of operation meets the requirements of subsection (1).

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

(d) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may in his discretion consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with [section 13]; and

(vi) any additional information as the commissioner may reasonably require.

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to [section 6].

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to [section 3] or by independent investigation, ~~is-contrary-to--the--public interest~~ VIOLATES ANY PROVISION OF [SECTIONS 1 THROUGH 29] OR RULES ADOPTED BY THE COMMISSIONER OR THE DEPARTMENT OF HEALTH.

(g) Any deficiencies identified by the department of health have been corrected.

(4) The commissioner may in his discretion deny a certificate of authority only if he complies with the requirements of [section 21].

NEW SECTION. Section 5. Powers of health maintenance organizations. (1) The powers of a health maintenance organization include but are not limited to the following:

(a) the purchase, lease, construction, renovation, operation, or maintenance of a hospital, a medical facility, or both, its ancillary equipment, and such property as may reasonably be required for its principal office or for such purposes as may be necessary in the transaction of the business of the organization;

(b) the making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation under its control for the purpose of acquiring or constructing a medical facility or hospital or in furtherance of a program providing health care services to enrollees;

(c) the furnishing of health care services through a provider who is under contract with or employed by the health maintenance organization;

(d) the contracting with a person for the performance on its behalf of certain functions, such as marketing,

enrollment, and administration;

(e) the contracting with an insurer authorized to transact insurance in this state, or with a health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization; and

(f) the offering of other health care services in addition to basic health care services.

(2) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner before exercising a power granted in subsection (1)(a), (1)(b), or (1)(d). The commissioner may, AFTER NOTICE AND HEARING, WITHIN 60 DAYS disapprove the exercise of a power UNDER SUBSECTION (1)(A), (1)(B), OR (1)(D) only if, in his opinion, it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. The commissioner may make reasonable rules exempting from the filing requirement of this subsection those activities having a de minimis effect. ~~The--exercise of--authority--granted--in--subsections--(1)(a),-(1)(b),-and (1)(d)-is-subject-to-disapproval-by--the--commissioner.~~ The commissioner may exempt certain contracts from the filing requirement whenever exercise of the authority granted in

this section would have little or no effect on the health maintenance organization's financial condition and ability to meet obligations.

(3) Nothing in this section exempts the activities of a health maintenance organization from any applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 6. Governing body. (1) The governing body of a health maintenance organization may include providers or other individuals, or both.

(2) The governing body shall establish a mechanism to give the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

NEW SECTION. Section 7. Fiduciary responsibilities. (1) Any director, officer, employee, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the health maintenance organization is responsible for the funds in the manner of a fiduciary to the health maintenance organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be

prescribed by the commissioner. Each bond must be written with at least a 1-year discovery period and, if written with less than a 3-year discovery period, must contain a provision that a cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, may not take effect prior to the expiration of 90 days after written notice of the cancellation or termination has been filed with the commissioner unless the commissioner approves an earlier cancellation or termination date.

NEW SECTION. Section 8. Evidence of coverage and charges for health care services. (1) Every enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment

to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is ~~unjust, unfair, inequitable, misleading, or deceptive, that encourages misrepresentation, or that is~~ untrue, misleading, or deceptive as defined in [section 14(1)]. The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

(b) definitions of geographical service area,

emergency care, urgent care, out-of-area services, dependent, and primary provider, if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment, which is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

(i) emergency and urgent care;

(ii) restrictions on the selection of primary or referral providers;

(iii) restrictions on changing providers during the contract period;

(iv) out-of-pocket costs, including copayments and deductibles;

(v) charges for missed appointments or other administrative sanctions;

(vi) restrictions on access to care if copayments or other charges are not paid; and

(vii) any restrictions on coverage for dependents who

do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or his dependents;

(f) a provision ~~offering~~ REQUIRING medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits AND COVERAGE provided in ~~33-22-703~~ TITLE 33, CHAPTER 22, PART 7; HOWEVER:

(I) AFTER THE PRIMARY CARE PHYSICIAN REFERS AN ENROLLEE FOR TREATMENT OF AND APPROPRIATE ANCILLARY SERVICES FOR MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION, THE HEALTH MAINTENANCE ORGANIZATION MAY NOT LIMIT THE ENROLLEE TO A HEALTH MAINTENANCE ORGANIZATION PROVIDER FOR THE TREATMENT OF AND APPROPRIATE ANCILLARY SERVICES FOR MENTAL ILLNESS, ALCOHOLISM, OR DRUG ADDICTION;

(II) IF AN ENROLLEE CHOOSES A PROVIDER OTHER THAN THE HEALTH MAINTENANCE ORGANIZATION PROVIDER FOR SUCH TREATMENT AND REFERRAL SERVICES, THE ENROLLEE'S DESIGNATED PROVIDER MUST LIMIT HIS TREATMENT AND SERVICES TO THE SCOPE OF THE

REFERRAL IN ORDER TO RECEIVE PAYMENT FROM THE HEALTH MAINTENANCE ORGANIZATION;

(III) THE AMOUNT PAID BY THE HEALTH MAINTENANCE ORGANIZATION TO THE ENROLLEE'S DESIGNATED PROVIDER MAY NOT EXCEED THE AMOUNT PAID BY THE HEALTH MAINTENANCE ORGANIZATION TO ONE OF ITS PROVIDERS FOR EQUIVALENT TREATMENT OR SERVICES;

(g) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is hereby amended to conform to the minimum requirements of those statutes."

(h) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, his dependents, or family members continuing coverage on the enrollee, his dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, his dependents, or family members covered under the evidence of coverage ceases because of termination of employment or of his membership in the class or classes eligible for coverage under the policy or because his employer discontinues his business or the coverage;

(ii) if the enrollee had been enrolled in the health

maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(i) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains

any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or his dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee must not be individually determined based on the status of his health. ~~However, the charges may not be excessive, inadequate, or unfairly discriminatory and cannot be amended more often than once in a 12-month period unless a more frequent~~

amendment is actuarially justified and necessary to preserve the financial solvency of the health maintenance organization. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the charges, based on reasonable assumptions, must accompany the filing, along with adequate supporting information.

(7) The commissioner shall, within a reasonable period 60 DAYS, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form or use a schedule of charges before the commissioner approves the form or the health maintenance organization files the schedule of charges. If the commissioner disapproves the filing, he shall notify the filer. In the notice, the commissioner shall specify the reasons for his disapproval. The commissioner shall grant a hearing within 30 days after he receives a written request by the filer.

(8) The commissioner may in his discretion require a health maintenance organization to submit any RELEVANT information he considers necessary in determining whether to approve or disapprove a filing made pursuant to this section.

NEW SECTION. Section 9. Annual statement -- revocation for failure to file -- penalty for perjury. (1)

Each UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN, EACH authorized health maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may in his discretion waive any verification under oath.

(2) At the time of filing its annual statement, the health maintenance organization shall pay the commissioner the fee for filing its statement as prescribed in [section 22]. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in [section 22], or may in his discretion suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due.

(3) The commissioner may, AFTER NOTICE AND HEARING, impose a fine not to exceed $5,000 per violation upon a director, officer, partner, member, agent, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement which is

false.

(4) The commissioner may require such reports as he considers reasonably necessary and appropriate to enable him to carry out his duties under [sections 1 through 29], INCLUDING BUT NOT LIMITED TO A STATEMENT OF OPERATIONS, TRANSACTIONS, AND AFFAIRS OF A HEALTH MAINTENANCE ORGANIZATION OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN.

NEW SECTION. Section 10. Information to enrollees. Each authorized health maintenance organization shall ~~promptly~~ provide to its enrollees ~~notice~~ 30 DAYS' ADVANCE NOTICE IN WRITING of any material change in the operation of the health maintenance organization that will affect them directly.

NEW SECTION. Section 11. Complaint system. (1) (a) Each authorized health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures to resolve written complaints initiated by enrollees. A health maintenance organization may not use a complaint system:

(i) before the commissioner approves it; and

(ii) unless the health maintenance organization describes it in each evidence of coverage issued or delivered to an enrollee in this state.

(b) Each time the health maintenance organization

denies a claim or initiates disenrollment, cancellation, or nonrenewal, it shall notify the affected enrollee of the right to file a complaint and the procedure for filing a complaint.

(c) Each health maintenance organization shall acknowledge a complaint within 10 days of receiving it.

(d) Each health maintenance organization shall retain records of all complaints for 3 years and shall develop a summary for each year that must include:

(i) a description of the procedures of the complaint system;

(ii) the total number of complaints handled through the complaint system, a compilation of causes underlying the complaints filed, the date on which each complaint was filed, the date on which each complaint was resolved, the disposition of each complaint filed, the time it took to process each complaint, and a summary of each administrative change made because of a complaint; and

(iii) the number, amount, and disposition of malpractice claims made by enrollees of the health maintenance organization that were settled during the year by the health maintenance organization.

(e) The health maintenance organization shall annually on or before March 1 file with the commissioner the summary described in subsection (1)(d) for the preceding year.

(2) The commissioner shall hold in confidence the information provided by the health maintenance organization pursuant to subsection (1)(d)(iii).

(3) The commissioner may examine a complaint system.

NEW SECTION. Section 12. Investment regulations. A EXCEPT FOR A HEALTH MAINTENANCE ORGANIZATION OPERATED AS A PLAN BY A HEALTH SERVICE CORPORATION, A domestic health maintenance organization may invest its funds only as prescribed in ~~rules adopted by the commissioner~~ TITLE 33, CHAPTER 2, PART 8.

NEW SECTION. Section 13. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation must be the greater of:

(a) 5% of its estimated expenditures for health care services for its first year of operation;

(b) twice its estimated average monthly uncovered expenditures for its first year of operation; or

(c) $100,000.

(3) At the beginning of each succeeding year, unless

not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on [the effective date of this act] shall make a deposit equal to the greater of:

(a) 1% of the preceding 12 months' uncovered expenditures; or

(b) $100,000 on the first day of the fiscal year beginning 6 months or more after [the effective date of this act]. In the second fiscal year, if applicable, the amount of the additional deposit must be equal to 2% of its estimated annual uncovered expenditures. In the third fiscal year, if applicable, the additional deposit must be equal to 3% of its estimated annual uncovered expenditures for that year. In the fourth fiscal year and subsequent years, if applicable, the additional deposit must be equal to 4% of its estimated annual uncovered expenditures for each year. Each year's estimate after the first year of operation must reasonably reflect the preceding year's operating experience and delivery arrangements.

(5) The commissioner may in his discretion waive any of the deposit requirements set forth in subsections (1)

through (4) whenever he is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to assure its financial viability for the next year;

(b) the health maintenance organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to assure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth not including land, buildings, and equipment of at least $1 million or achieves a net worth including organization-related land, buildings, and equipment of at least $5 million the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth not including land,

buildings, and equipment of at least $1 million or that has been in operation for at least 10 years and has a net worth including organization-related land, buildings, and equipment of at least $5 million, the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of such health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not

required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by $100,000 for each $250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit $100,000 for each $250,000 of reduction in net worth, except that its total deposit may not be required to exceed the maximum required under this section.

(9) Each UNLESS IT IS OPERATED BY AN INSURER OR A HEALTH SERVICE CORPORATION AS A PLAN, EACH health maintenance organization shall have a minimum capital of at least $200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

(a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

(b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical

underwriting or preexisting limitation requirements.

NEW SECTION. Section 14. Prohibited practices. (1) A health maintenance organization, or representative thereof, may not cause or knowingly permit the use of advertising that is untrue or misleading, solicitation that is untrue or misleading, or any form of evidence of coverage that is deceptive. For purposes of [sections 1 through 29]:

~~(a) a statement or item of information is considered to be untrue if it does not conform to fact in any respect that is or may be significant to an enrollee of, or person considering enrollment in, a health maintenance organization;~~

~~(b)~~(A) a statement or item of information is considered to be misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, a reasonable person, not possessing special knowledge regarding health care coverage, may reasonably understand the statement or item of information as indicating a benefit or advantage or the absence of an exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health maintenance organization if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist; and

~~(c)~~(B) an evidence of coverage is considered to be deceptive if, when taken as a whole and with consideration given to typography, format, and language, it can cause a reasonable person, not possessing special knowledge regarding health maintenance organizations, to expect benefits, services, charges, or other advantages that the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage does not regularly make available to enrollees covered under the evidence of coverage.

(2) Title 33, chapter 18, applies to health maintenance organizations and evidences of coverage issued by a health maintenance organization, except to the extent that the commissioner determines that the nature of health maintenance organizations and evidences of coverage render the chapter clearly inappropriate.

(3) A health maintenance organization shall clearly disclose in the evidence of coverage the circumstances under which it may disenroll, cancel, or refuse to renew an enrollee. A health maintenance organization may only disenroll, cancel, or refuse to renew an enrollee if the enrollee:

(a) has failed to pay required premiums by the end of the grace period;

(b) has committed acts of physical or verbal abuse

that pose a threat to providers or other enrollees of the health maintenance organization;

(c) has allowed a nonenrollee to use the health maintenance organization's certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;

(d) has moved outside of the geographical service area of the health maintenance organization; ~~or~~

(E) HAS VIOLATED RULES OF THE HEALTH MAINTENANCE ORGANIZATION STATED IN THE EVIDENCE OF COVERAGE;

(F) HAS VIOLATED RULES ADOPTED BY THE COMMISSIONER FOR ENROLLMENT IN A HEALTH MAINTENANCE ORGANIZATION; OR

~~(e)~~(G) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the health maintenance organization can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that he may file a grievance on this matter.

(4) A health maintenance organization may not disenroll an enrollee under subsection (3) for reasons related to the physical or mental condition of the enrollee

or for any of the following reasons:

(a) failure of the enrollee to follow a prescribed course of treatment; or

(b) administrative actions, such as failure to keep an appointment.

(5) (a) A health maintenance organization that disenrolls a group certificate holder for any reason ~~except failure to pay required premiums~~ NOT LISTED IN SUBSECTION (3) OR PROVIDED IN RULES ADOPTED BY THE COMMISSIONER shall make arrangements to provide similar alternate insurance coverage to enrollees. The insurance coverage must be continued until the disenrolled group certificate holder finds its own coverage or a period of ~~36~~ 12 months elapses, whichever comes first. The premium on the individual coverage must be at the then-customary rate applicable to the individual coverage offered by the insurer, health service corporation, or health maintenance organization that provides the alternate insurance coverage.

(b) If a health maintenance organization disenrolls an enrollee covered on an individual basis for any reason ~~except failure to pay required premiums~~ NOT LISTED IN SUBSECTION (3) OR PROVIDED IN RULES ADOPTED BY THE COMMISSIONER, coverage must be continued until the anniversary date of the policy or for 1 year, whichever is earlier. A health maintenance organization that disenrolls

an individual enrollee for failure to pay a required premium or for fraudulent statements on the enrollment form need not provide alternate insurance coverage to that enrollee.

(6) A health maintenance organization may not refer to itself as an insurer unless licensed as an insurer or use a name deceptively similar to the name or description of an insurer authorized to transact insurance in this state.

(7) A person may not refer to itself as a health maintenance organization or HMO unless it holds a valid certificate of authority issued by the commissioner.

NEW SECTION. Section 15. Agent license required -- application, issuance, renewal, fees -- penalty. (1) No individual, partnership, or corporation may act as or hold himself out to be an agent of a health maintenance organization unless he is:

(a) licensed as a disability insurance agent by the commissioner pursuant to chapter 17, parts 1, 2, and 4 of this title OR LICENSED AS AN ENROLLMENT REPRESENTATIVE UNDER 33-30-311 THROUGH 33-30-313; and

(b) appointed or authorized by the health maintenance organization to solicit health care service agreements on its behalf.

(2) Application, appointment and qualification for a health maintenance organization agent license, fees applicable to and the issuance of a health maintenance

organization agent license, and renewal of a health maintenance organization agent license must be in accordance with the provisions of chapter 17 that apply to a disability insurance agent.

(3) An individual, partnership, or corporation who holds a disability insurance agent license on [the effective date of this act] need not requalify by an examination to be licensed as a health maintenance organization agent.

(4) The commissioner may, in accordance with 33-1-313, 33-1-317, 33-17-411, and chapter 17, part 10, suspend, revoke, refuse to issue or renew a health maintenance organization agent license, or impose a fine upon the licensee.

NEW SECTION. Section 16. Powers of insurers and health service corporations. (1) An insurer authorized to transact insurance in this state or a health service corporation authorized to do business in this state may, either directly or through a subsidiary or affiliate, organize and operate a health maintenance organization under the provisions of [sections 1 through 29]. Notwithstanding any other law which may be inconsistent with this section, two or more insurers, health service corporations, or subsidiaries or affiliates thereof may jointly organize and operate a health maintenance organization. The business of insurance is considered to include the provision of health

care services by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any insurance or health service corporation laws, an insurer or a health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through a health maintenance organization and to provide coverage if the health maintenance organization fails to meet its obligations.

(3) The enrollees of a health maintenance organization constitute a permissible group under this title. The insurer or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers under the contracts described in subsection (2).

(4) Nothing in this section exempts a health maintenance organization that provides health care services from complying with the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 17. Examination. (1) The commissioner may examine the affairs of a health maintenance organization ~~and--the--providers--with--whom---the---health maintenance-organization-has-contracts,-agreements,-or-other arrangements~~ as often as is reasonably necessary to protect the interests of the people of this state. The commissioner

shall make such an examination at least once every 3 years.

(2) The department of health may examine the ~~quality~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY of the health care services provided by any health maintenance organization and the providers with whom the health maintenance organization has contracts, agreements, or other arrangements as often as is reasonably necessary to protect the interests of the people of this state. The department of health shall make such an examination at least once every 3 years.

(3) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner and the department of health may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of the providers concerning their business.

(4) (a) (i) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or

adopted by the commissioner. The commissioner may present such an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any such examination.

(ii) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (4)(a)(i), the commissioner shall pay them out of the funds of the commissioner in the same manner as other disbursements of such funds. The amount so paid must be a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund.

(b) The expenses of examination conducted by the director under this section must be assessed against the health maintenance organization and remitted to the director. Such remitted expenses are statutorily appropriated to the department of health as provided in 17-7-502.

(5) In lieu of an examination, the commissioner or the director may accept the report of an examination made by the commissioner or the director of another state.

NEW SECTION. Section 18. Suspension or revocation of

certificate of authority. (1) The commissioner may in his discretion suspend or revoke any certificate of authority issued to a health maintenance organization under [sections 1 through 29] if he finds that any of the following conditions exist:

(a) The health maintenance organization is operating in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under [section 3] AND PROVIDED THAT SUCH OPERATION ADVERSELY AFFECTS THE HEALTH MAINTENANCE ORGANIZATION'S ABILITY TO PROVIDE BENEFITS AND OPERATE UNDER THE APPLICATION APPROVED BY THE COMMISSIONER, unless amendments to such submissions have been filed with and approved by the commissioner.

(b) The health maintenance organization issues evidences of coverage or uses a schedule of charges for health care services that do not comply with the requirements of [section 8].

(c) The health maintenance organization does not provide or arrange for basic health care services.

(d) The director, AFTER NOTICE AND HEARING, certifies to the commissioner that:

(i) the health maintenance organization does not meet the requirements of [section 4(1)]; or

(ii) the health maintenance organization is unable to

fulfill its obligations to furnish health care services.

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

(f) The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under [section 6].

(g) The health maintenance organization has failed to implement the complaint system required by [section 11] to resolve valid complaints in a reasonable manner.

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees.

(j) The health maintenance organization has otherwise failed to substantially comply with [sections 1 through 29].

(2) The commissioner may in his discretion suspend or revoke a certificate of authority only if he complies with the requirements of [section 21].

(3) When the certificate of authority of a health maintenance organization is suspended, the health

maintenance organization may not, during the period of such suspension, enroll any additional enrollees except newborn infants or other newly acquired dependents of existing enrollees and may not engage in any advertising or solicitation.

(4) If the commissioner revokes the certificate of authority of a health maintenance organization, the health maintenance organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and may not transact further business except as may be essential to the orderly conclusion of its affairs. It may not engage in further advertising or solicitation following the effective date of the order of revocation. The commissioner may by written order permit further operation of the health maintenance organization if he finds further operation to be in the best interest of enrollees to the extent that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

NEW SECTION. Section 19. Supervision, rehabilitation, or liquidation of a health maintenance organization. (1) The supervision, rehabilitation, or liquidation of a health maintenance organization is considered to be the supervision, rehabilitation, or liquidation of an insurer and must be conducted under the supervision of the

commissioner pursuant to chapter 2, part 13. The commissioner may apply for an order directing him to supervise, rehabilitate, or liquidate a health maintenance organization upon any one or more grounds set out in 33-2-1321, 33-2-1331, or 33-2-1341 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as a claim by an enrollee if the provider of services agrees not to assert the claim against any enrollee of the health maintenance organization.

NEW SECTION. Section 20. Rules. (1) The commissioner may, after notice and hearing, make reasonable rules necessary to effectuate [sections 1 through 29].

(2) The department of health may make reasonable rules necessary to effectuate [sections 1 through 29].

NEW SECTION. Section 21. Administrative procedures. (1) When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist or that grounds for the suspension or revocation of a certificate of authority exist, he shall give written notice to the health maintenance organization

and the department of health specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least 30 days after the notice for a hearing on the matter.

(2) The director or his designated representative may attend the hearing and may participate in the proceeding. The recommendations and findings of the director with respect to matters relating to the ~~quality~~ AVAILABILITY, ACCESSIBILITY, AND CONTINUITY of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority must be conclusive and binding upon the commissioner. After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall make written findings and act as he considers advisable. The commissioner shall mail the written findings to the health maintenance organization and submit a copy to the director. The action of the commissioner and the recommendations and findings of the director are subject to review by the district court having jurisdiction. The court may, in disposing of the issue before it, modify, affirm, or reverse the order of the commissioner in whole or in part.

(3) ~~The Montana Administrative Procedure Act, Title 2, chapter 4, applies to proceedings under this section to the extent it is not in conflict with this section.~~ WHERE NOTICE

AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE COMMISSIONER UNDER [SECTIONS 1 THROUGH 29], THE REQUIREMENTS OF 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, APPLY, EXCEPT THAT THE FORMAL RULES OF PLEADING AND EVIDENCE MUST BE OBSERVED. TO THE EXTENT THAT 33-1-314 THROUGH 33-1-316 AND TITLE 33, CHAPTER 1, PART 7, DO NOT ADDRESS THE NOTICE AND HEARING REQUIREMENTS OF [SECTIONS 1 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7, APPLY.

(4) WHERE NOTICE AND HEARING ARE REQUIRED WITH REGARD TO ACTIONS TAKEN BY THE DIRECTOR UNDER [SECTIONS 1 THROUGH 29], THE PROVISIONS OF TITLE 2, CHAPTER 4, PARTS 6 AND 7, APPLY.

NEW SECTION. Section 22. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

(a) for filing an application for a certificate of authority or amendment thereto, $300;

(b) for filing an amendment to the organization documents that requires approval, $25;

(c) for filing each annual statement, $25;

(D) FOR ANNUAL CONTINUATION OF CERTIFICATE OF AUTHORITY, $300.

(2) All fees and miscellaneous charges, except fines or penalties or those amounts received pursuant to [sections

9(3) and 23], collected by the commissioner pursuant to [sections 1 through 29] and the rules adopted thereunder must be deposited in the insurance regulatory trust account pursuant to 17-2-121 through 17-2-123.

(3) The director may assess fees necessary and adequate to cover the expenses of the director's functions~~, other--than--examinations,~~ under this chapter. ~~Such-fees-are statutorily-appropriated-to--the--department--of--health--as provided--in--17-7-502.~~ ~~THESE-FEES-MUST-BE-DEPOSITED-IN-THE GENERAL-FUND.~~ SUCH FEES ARE STATUTORILY APPROPRIATED TO THE DEPARTMENT OF HEALTH AS PROVIDED IN 17-7-502.

NEW SECTION. Section 23. Penalties and enforcement. (1) The commissioner may, in addition to suspension or revocation of a certificate of authority under [section 18], AFTER NOTICE AND HEARING, impose an administrative penalty in an amount not less than $500 or more than $10,000 if he gives reasonable notice in writing of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations that gave rise to the penalty citation. ~~The commissioner-may-augment-this-penalty-by-an-amount-equal--to the--sum--that--he--calculates-to-be-the-damages-suffered-by enrollees-or-other-members-of-the-public.~~

(2) ~~(a)~~ If the commissioner or the director has cause to believe that a violation of [sections 1 through 29] has

occurred or is threatened, the commissioner or the director may:

~~(i)~~(A) give notice to the health maintenance organization and to the representatives or other persons who appear to be involved in the suspected violation;

~~(ii)~~(B) arrange a conference with the alleged violators or their authorized representatives to attempt to ascertain the facts relating to the suspected violation; and

~~(iii)~~(C) if it appears that a violation has occurred or is threatened, arrive at an adequate and effective means of correcting or preventing the violation.

~~(b)--Proceedings-under-this-subsection-are-not-governed by-any-formal-procedural-requirements-and-may--be--conducted in--a--manner--the--commissioner--or--the-director-considers appropriate--under--the---circumstances.---However,---unless consented-to-by-the-health-maintenance-organization,-no-rule or-order-may-result-from-a-conference-until-the-requirements of-[section-21]-or-this-section-are-satisfied.~~

(3) (a) The commissioner may issue an order directing a health maintenance organization or its representative to cease and desist from engaging in an act or practice in violation of [sections 1 through 29].

(b) Within 15 days after service of the cease and desist order, the respondent may request a hearing to determine whether acts or practices in violation of

[sections 1 through 29] have occurred. The hearing must be conducted pursuant to Title 2, chapter 4, part 6, and judicial review must be available as provided by Title 2, chapter 4, part 7.

(4) If a health maintenance organization violates a provision of [sections 1 through 29] and the commissioner elects not to issue a cease and desist order or if the respondent does not comply with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court of Lewis and Clark County.

NEW SECTION. Section 24. Statutory construction and relationship to other laws. (1) Except as otherwise provided in [sections 1 through 29], the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under [sections 1 through 29]. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to [sections 1 through 29].

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its

representatives may not be construed as a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under [sections 1 through 29] may not be considered to be practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) The provisions of [sections 1 through 29] do not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

NEW SECTION. Section 25. Filings and reports as public documents. All applications, filings, and reports required under [sections 1 through 29], except those that contain trade secrets or privileged or confidential commercial or financial information (other than an annual financial statement that the commissioner may require under [section 9]), are public documents.

NEW SECTION. Section 26. Confidentiality of medical information. (1) Any data or information pertaining to the diagnosis, treatment, or health of an enrollee or applicant obtained from the enrollee, applicant, or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except:

(a) to the extent that it may be necessary to carry

out the purposes of [sections 1 through 29];

(b) upon the express consent of the enrollee or applicant;

(c) pursuant to statute or court order for the production of evidence or the discovery thereof; or

(d) in the event of claim or litigation between the enrollee or applicant and the health maintenance organization wherein the data or information is pertinent.

(2) A health maintenance organization is entitled to claim the same statutory privileges against disclosure that the provider who furnished the information to the health maintenance organization is entitled to claim.

NEW SECTION. Section 27. Authority of director to contract. The director in carrying out his obligations under [sections 4(1), 17(2), and 18(1)] may contract with qualified persons to make recommendations concerning the determinations he is required to make. The contractors' recommendations may be accepted OR REJECTED in full or in part by the director.

NEW SECTION. Section 28. Acquisition, control, or merger of a health maintenance organization. (1) Except as provided in 33-2-1106 and subsection (2), no person may tender for, request, or invite tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health

maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the health maintenance organization.

(2) No person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request, or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the acquiring person has filed with the commissioner and has sent to the health maintenance organization information required by 33-2-1104(2) and the commissioner has approved the offer, request, invitation, agreement, or acquisition pursuant to 33-2-1105.

NEW SECTION. Section 29. Dual choice. ~~(1) Each public or private employer in this state that employs not less than 25 employees and offers its employees a health benefit plan and each employee benefit fund in this state that offers its members any form of disability insurance benefit shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority that provides health care services in the geographic areas in~~

which a substantial number of the employees or members reside. If there is a prevailing collective bargaining agreement, the selection of the health maintenance organization to be made available to the employees must be made pursuant to the agreement.

(2) An employer in this state THAT OFFERS ITS EMPLOYEES THE OPTION TO ENROLL IN A HEALTH MAINTENANCE ORGANIZATION AND AN EMPLOYEE BENEFIT FUND IN THIS STATE THAT OFFERS ITS MEMBERS THE OPTION TO ENROLL IN A HEALTH MAINTENANCE ORGANIZATION may not be required to pay more for health benefits as a result of the application of this section PROVIDED BY THE HEALTH MAINTENANCE ORGANIZATION than it would otherwise be required to provide by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, if the employer or benefits fund pays to the health maintenance organization chosen by each employee or member an amount equal to the lesser of:

(a)(1) the amount paid on behalf of its other employees or members of health benefits; or

(b)(2) the health maintenance organization's charge for coverage approved by the commissioner pursuant to [section 8].

Section 30. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All Except as provided in [sections 1 through 29], all policies of disability insurance, including individual, group, and blanket policies, and all policies insuring the payment of compensation under the Workers' Compensation Act shall provide the insured shall have full freedom of choice in the selection of any duly licensed physician, dentist, osteopath, chiropractor, optometrist, chiropodist, psychologist, licensed social worker, or nurse specialist as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of his practice. Whenever such policies insure against the expense of drugs, the insured shall have full freedom of choice in the selection of any duly licensed and registered pharmacist. An insurer shall offer, at additional cost to the insured, the option of disability and health insurance coverage for services performed by a licensed professional counselor.

(2) Nothing in this section shall be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1), nor shall this section be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

Section 31. Section 17-7-502, MCA, is amended to read:

"17-7-502. Statutory appropriations -- definition -- requisites for validity. (1) A statutory appropriation is an appropriation made by permanent law that authorizes spending by a state agency without the need for a biennial legislative appropriation or budget amendment.

(2) Except as provided in subsection (4), to be effective, a statutory appropriation must comply with both of the following provisions:

(a) The law containing the statutory authority must be listed in subsection (3).

(b) The law or portion of the law making a statutory appropriation must specifically state that a statutory appropriation is made as provided in this section.

(3) The following laws are the only laws containing statutory appropriations:

(a) 2-9-202;

(b) 2-17-105;

(c) 2-18-812;

(d) 10-3-203;

(e) 10-3-312;

(f) 10-3-314;

(g) 10-4-301;

(h) 13-37-304;

(i) 15-31-702;

(j) 15-36-112;

(k) 15-70-101;

(l) 16-1-404;

(m) 16-1-410;

(n) 16-1-411;

(o) 17-3-212;

(p) 17-5-404;

(q) 17-5-424;

(r) 17-5-804;

(s) 19-8-504;

(t) 19-9-702;

(u) 19-9-1007;

(v) 19-10-205;

(w) 19-10-305;

(x) 19-10-506;

(y) 19-11-512;

(z) 19-11-513;

(aa) 19-11-606;

(bb) 19-12-301;

(cc) 19-13-604;

(dd) 20-6-406;

(ee) 20-8-111;

(ff) 23-5-612;

(gg) [section 17];

(hh) [section 22];

(gg)(ii) 37-51-501;

~~(hh)~~ (jj) ~~53-24-206;~~

~~(ii)~~ (kk) ~~75-1-1101;~~

~~(jj)~~ (ll) ~~75-7-305;~~

~~(kk)~~ (mm) ~~80-2-103;~~

~~(ll)~~ (nn) ~~80-2-228;~~

~~(mm)~~ (oo) ~~90-3-301;~~

~~(nn)~~ (pp) ~~90-3-302;~~

~~(oo)~~ (qq) ~~90-15-103;~~ ~~and~~

~~(pp)~~ (rr) ~~Sec. 13, HB 861, L. 1985.~~

~~(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments.~~"

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legislative appropriation or budget amendment.

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(g) 10-4-301;

(h) 13-37-304;

(i) 15-31-702;

(j) 15-36-112;

(k) 15-70-101;

(l) 16-1-404;

(m) 16-1-410;

(n) 16-1-411;

(o) 17-3-212;
(p) 17-5-404;
(q) 17-5-424;
(r) 17-5-804;
(s) 19-8-504;
(t) 19-9-702;
(u) 19-9-1007;
(v) 19-10-205;
(w) 19-10-305;
(x) 19-10-506;
(y) 19-11-512;
(z) 19-11-513;
(aa) 19-11-606;
(bb) 19-12-301;
(cc) 19-13-604;
(dd) 20-6-406;
(ee) 20-8-111;
(ff) 23-5-612;
(gg) [section 17];
(hh) [section 22];
~~(gg)~~(ii) 37-51-501;
~~(hh)~~(jj) 53-24-206;
~~(ii)~~(kk) 75-1-1101;
~~(jj)~~(ll) 75-7-305;
~~(kk)~~(mm) 80-2-103;

~~(ll)~~(nn) 80-2-228;
~~(mm)~~(oo) 90-3-301;
~~(nn)~~(pp) 90-3-302;
~~(oo)~~(qq) 90-15-103; and
~~(pp)~~(rr) Sec. 13, HB 861, L. 1985.

(4) There is a statutory appropriation to pay the principal, interest, premiums, and costs of issuing, paying, and securing all bonds, notes, or other obligations, as due, that have been authorized and issued pursuant to the laws of Montana. Agencies that have entered into agreements authorized by the laws of Montana to pay the state treasurer, for deposit in accordance with 17-2-101 through 17-2-107, as determined by the state treasurer, an amount sufficient to pay the principal and interest as due on the bonds or notes have statutory appropriation authority for such payments."

SECTION 31. SECTION 33-1-102, MCA, IS AMENDED TO READ:

"33-1-102. Compliance required -- exceptions -- health service corporations. (1) No person shall transact a business of insurance in Montana or relative to a subject resident, located, or to be performed in Montana without complying with the applicable provisions of this code.

(2) No provision of this code shall apply with respect to:

(a) domestic farm mutual insurers as identified in

chapter 4, except as stated in chapter 4;

(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and

(c) fraternal benefit societies, except as stated in chapter 7.

(3) This code shall not apply to health service corporations to the extent that the existence and operations of such corporations are authorized by Title 35, chapter 2, and related sections of the Montana Code Annotated.

(4) This code does not apply to health maintenance organizations to the extent that the existence and operations of such organizations are authorized by [sections 1 through 29]."

SECTION 32. SECTION 33-1-704, MCA, IS AMENDED TO READ:

"33-1-704. Hearing procedure. (1) All hearings shall be open to the public unless closed pursuant to the provisions of 2-3-203.

(2) The commissioner shall allow any party to the hearing to appear in person and by counsel, to be present during the giving of all evidence, to have a reasonable opportunity to inspect all documentary evidence and to examine witnesses, to present evidence in support of his interest, and to have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(3) The commissioner shall permit to become a party to the hearing by intervention, if timely, any person who was not an original party thereto and whose pecuniary interests will be directly and immediately affected by the commissioner's order made upon the hearing.

(4) ~~Formal~~ Except as provided in [section 21], rules of pleading or evidence need not be observed at any hearing.

(5) Upon written request seasonably made by a party to the hearing and at that person's expense, the commissioner shall cause a full stenographic record of the proceedings to be made by a competent reporter. If transcribed, a copy of such stenographic record shall be furnished to the commissioner without cost to the commissioner or the state and shall be a part of the commissioner's record of the hearing. If so transcribed, a copy of such stenographic record shall be furnished to any other party to such hearing at the request and expense of such other party. If no stenographic record is made or transcribed, the commissioner shall prepare an adequate record of the evidence and of the proceedings."

NEW SECTION. Section 33. Codification instruction. Sections 1 through 29 are intended to be codified as an integral part of Title 33, and the provisions of Title 33 apply to sections 1 through 29.

NEW SECTION. Section 34. Severability. If a part of

this act is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of this act is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 35. Effective date -- applicability. ~~This--act-is~~ SECTION 20 AND THIS SECTION ARE effective on passage and approval ~~and~~. THIS ACT applies to health maintenance organizations formed before or after the effective date of this act.

-End-